Calendar No. 776

95TH CONGRESS
2d Session

SENATE

REPORT
No. 95-845

HEALTH PLANNING AMENDMENTS OF 1978

MAY 15 (legislative day, APRIL 24), 1978.—Ordered to be printed

Mr. KENNEDY, from the Committee on Human Resources, submitted the following

REPORT

[To accompany S. 2410]

The Committee on Human Resources, to which was referred the bill (S. 2410) to amend titles XV and XVI of the Public Health Service Act to revise and extend the authorities and requirements under those titles for health planning and health resources development, having considered the same, reports favorably thereon with an amendment in the nature of a substitute and recommends that the bill as amended do pass.

CONTENTS

I. SUMMARY OF THE BILL

S. 2410, the Health Planning Amendments of 1978, as reported extends the authorities and revises the requirements under titles XV and XVI of the Public Health Service Act for health planning and health resources development. The bill also adds a new part G under title XVI providing for the establishment of a program to assist and encourage the voluntary discontinuance of unneeded hospital services.

TITLE I

Title I of the bill revises and extends the national health planning and development authority under title XV of the PHS act. It makes a number of revisions in the existing program in order to accomplish the following:

(1) Assure effective consumer participation through requirements for HSA staff to be assigned to consumer board members, an open selection process for HSA members in which current members may not select new members, improved liability protection for HSA and SHCC members, consumer majorities on HSA subcommittees, advance payments for HSA members' expenses;

(2) Provide that the State health plan developed by the SHCC is to have the concurrence of the Governor and that the SHCC and HSA's are to develop a uniform format for use by HSA's in developing their health systems plans (HSP's);

(3) Specify the material to be included in the health systems plans of HSA's and the preliminary State health plans prepared by the State agencies for use by SHCC's;

(4) Assure that certificate of need decisions are consistent with the State health plan and that approved certificates of need are reviewed for progress at least once every 24 months (with provision for withdrawal of approval in the absence of substantial progress);

(5) Extend requirements for certificate of need review to all medical equipment valued over $150,000, regardless of location, but also provide that only those new institutional health services entailing annual operating costs of $50,000 or more will be subject to certificate of need review;

(6) Provide that each certificate of need be based solely on the record established in administrative and judicial proceedings;

(7) Stipulate procedures and criteria for review by HSA's and State agencies for purposes of certificate of need, appropriateness of existing services, and certain other purposes;

(8) Assure representation of medical underserved populations, especially in rural areas, through explicit provisions for their representation on health systems agencies (HSA's), statewide health coordinating councils (SHCC's), and the National Council for Health Planning;

(9) Provide for 3-year designation of health systems agencies and State agencies, rather than the 1-year period now authorized;

(10) Clarify procedures for redesignation of health services areas, including those involving standards metropolitan statistical areas (SMSA's);

(11) Increase minimum funding levels for small population HSA's and permit 5 percent of HSA planning grant appropriations to be used to increase grants to HSA's with extraordinary expenses due to a large health service area, large rural or urban medical underserved populations, and so forth;

(12) Redefine the requirements for public HSA's to allow for the parent governing body to retain certain responsibilities for personnel rules, budget approval, and so forth, rather than delegating these functions to the separate body for health planning;

(13) Improve coordination between health planning entities and appropriate drug abuse, alcohol abuse, mental health, area agencies on aging, and rate review authorities and emphasize that health care also refers to mental health care; and

(14) Provide for a variety of other purposes.

The bill authorizes appropriations in the following amounts for the purposes of title XV: for planning grants to health systems agencies—$150 million for fiscal year 1979, $175 million for fiscal year 1980, and $200 million for fiscal year 1981; for grants to State health planning and development agencies—$40 million for fiscal year 1979, $45 million for fiscal year 1980, and $50 million for fiscal year 1981; for grants to State rate regulation programs—$6 million for fiscal year 1979, $7 million for fiscal year 1980, and $7 million for fiscal year 1981; for grants to Centers for Health Planning—$12 million for fiscal year 1979, $15 million for fiscal year 1980, and $18 million for fiscal year 1981.

TITLE II

Title II of the bill revises and extends the health resources development authority under title XVI of the PHS Act. It provides that the Governor as well as the SHCC must approve the State medical facilities plan. It authorizes appropriations in the following amounts for the purposes of title XVI: for allotments to the States under section 1610—$135 million for fiscal years 1979, 1980, and 1981; for loans and loan guarantees under section 1622(d)—such sums as may be necessary for fiscal years 1979, 1980, and 1981; for project grants for elimination of safety hazards or to meet accredition standards, as provided under section 1625—$75 million for fiscal year 1979, $100 million for fiscal year 1980, and $125 million for fiscal year 1981; for grants for area health services development funds under section 1640(a)—$120 million for fiscal year 1979, $150 million for fiscal year 1980, and $180 million for fiscal year 1981.

Title II also establishes under a new part G a program to assist and encourage the voluntary discontinuance of unneeded hospital services. Any hospital in operation on the date of enactment of this Act and which (1) intends to discontinue providing all inpatient health services could apply for a debt payment and an incentive payment for this discontinuance; (2) intends to discontinue an identifiable unit of the hospital that provides inpatient health services could apply for an incentive payment; or (3) intends to convert an identifiable part of the hospital into providing long-term services, ambulatory care services, or any other service designated by the Secretary could apply for a conversion payment, if the State Agency has determined that such new service is needed. The bill authorizes appropriation in the following amounts for purposes of the new part G program: $150 million for fiscal year 1979, $200 million for fiscal year 1980, and $150 million for fiscal year 1981.

TITLE III

Title III of the bill contains miscellaneous amendments repealing obsolete sections under title III of the Act and repealing title IX of the Act in its entirety.

II. Need for Legislation/History of the Program

Federal efforts on behalf of national health planning and resources development have undergone several transformations. Over 30 years ago, Congress enacted as part of the Hill-Burton hospital construction program a requirement that States survey their need for various health facilities and develop individual State plans to meet those needs. During the 1960's, several additional health planning efforts were superimposed on the existing Hill-Burton structure—specifically the areawide voluntary health facilities planning councils, which came about through the Hill-Harris Amendments of 1964 (Public Law 88–443); the regional medical programs, or RMP's, enacted in 1965 under Public Law 89–239; and the comprehensive health planning program, or CHP, enacted in 1966 under public Law 89–749.

Although these programs made many notable contributions, their record with regard to effective health planning and resource allocation could hardly be termed a success. Extensive hearings conducted in the 93rd Congress revealed that the planning entities suffered from austere financing, overlap and duplication of responsibilities, and absence of sufficient mandate for implementation of their plans. Additionally, there was inadequate Federal guidance as to national health priorities and goals. Planning agencies were in turn accused of knuckling under to the Nation's health providers and paying scant attention to the all-important cost implications of their decisions.

Concern over the fragmentation and mixed success of these earlier planning efforts led Congress in 1974 to combine and integrate these programs through enactment of the National Health Planning and Resources Development Act of 1974 (Public Law 93–641). In developing the legislation which led to Public Law 93–641, this committee sought to avoid some of the problems which had plagued earlier programs. For example, clearer lines of authority were drawn with responsibilities and accountability specifically detailed. Broader mandates were provided for actual implementation of the short- and long-range plans developed by the planning bodies. Stronger sanctions were authorized, along with improved funding arrangements, so that agencies would not be dependent on contributions from health care providers, as had often been the case under the predecessor programs. Extensive care was taken so that the point of view of those that utilize health care resources would be fully represented and that the provider-domination of planning agency decisions, which had been such a critical factor in the past, would be significantly reduced.

The legislation recognized State certificate-of-need programs to be the basic component in an overall effort to control the unnecessary capital expenditures which contribute so greately to the total national health bill.

The development of new health resources was tied directly to approved State medical facilities plans. Health systems agencies were to be given special funds to encourage development of needed health resources and services in their respective areas.

Congress drew up an ambitious array of responsibilities for the thousands of individuals in State and local planning agencies who would be involved in implementing the program. Health planners were to address themselves to improvements in the health of area

residents and in the accessibility, acceptability, continuity, and quality of health services, to prevention of unnecessary duplication of resources, and to de-escalate the increasing costs of health care.

Since the law was enacted in 1974, the last issue—cost containment—has assumed even greater significance. National health expenditures tripled between 1965 and 1975. In fiscal year 1976, the annual expenditures for health totaled $139.3 billion, up 14 percent over the $122.2 billion spent in 1975. That rate of increase was approximately twice the rate of increase in the overall consumer price index for the same period. Without any intervention it has been estimated that this $139 billion spent on health care in 1976 will grow to $230 billion by 1980. Expenditures for hospital care—which account for 40 cents of every dollar Americans spend on health care—have been growing far faster than the overall cost-of-living for more than two decades.

In this climate of escalating health costs, effective health planning has become an essential component in the overall strategy to control future increases and to introduce priorities in the allocation and use of finite resources. After 3 years experience with the law, Congress is now in a position to assess the strengths and deficiencies of the program and to legislate the changes necessary to improve the process and fulfill the goals set forth in the original legislation.

The original authorities for titles XV and XVI of the Public Health Service Act as provided by Public Law 93–641 were due to expire at the end of fiscal year 1977. Legislation—Public Law 95–83—was passed by Congress and signed by the President on August 1, 1977, to provide a simple 1-year extension of these programs without substantive amendment to existing law. This was done because the congressional budget process required that consideration of legislation affecting fiscal year 1978 be completed by May 15, 1977, and this schedule did not afford the new administration sufficient time to review the planning law and programs, and prepare their own policy positions and proposals with respect to it. Thus, a 1-year extension was provided to give HEW an opportunity to conduct a thorough review of these programs and to permit Congress to undertake a full airing and consideration of issues in anticipation of substantive consideration of the law prior to the next May 15 reporting deadline.

Aside from the 1-year extension of authorizations provided under Public Law 95–83, no significant amendments have been made to the health planning and resources development program since its enactment in 1974. However, action was taken by Congress to enable HEW to extend conditional designation agreements for health systems agencies (HSA's) and State health planning and development agencies (SHPDA's) from the 24-month period specified in Public Law 93–641 to a period of up to 36 months. These provisions were contained in amendments to the Health Professions Education Amendments of 1977—Public Law 95–215.

During the first 24 months of conditional designation, only a handful of HSA's and SHPDA's had been able to comply with requirements for full designation. It was recognized that, without the provisions contained in Public Law 95–215, conditional designation agreements for most of the existing HSA's and SHPDA's would have expired before Congress could take up consideration of substantive changes in the health planning law. To avoid disrupting the excellent beginning

which had been made toward developing the basic structural mechanisms, it was felt that a 12-month extension in conditional designation agreements was warranted if the Secretary determined that unusual circumstances had prevented the various health planning entities from qualifying for full designation. This amendment was not to be used, however, simply to allow a marginal health systems agency another year of funding. The Secretary was directed to determine that the additional year would in all likelihood make the HSA qualified for full designation.

For those readers who wish a more indepth understanding of the history of the current planning law, a detailed description of the provisions in current law, and a detailed analysis of the progress in its implementation, the committee has developed two special sections for this report entitled "Detailed Description of Current Health Planning Law—(Public Law 93–641)" and "Progress in Implementation of the Health Planning Law—(Public Law 93–641)".

In preparation for more substantive consideration of amendments to the health planning program, the committee solicited over the course of the last year written comments from over 400 individuals and organizations concerned with the daily implementation of Public Law 93–641. As a result of this process, numerous thoughtful suggestions were incorporated into S. 2410 as originally introduced. Additional comments made in the course of public hearings before the Subcommittee on Health and Scientific Research on February 2, 3, and 6, 1978, led to various modifications which the committee feels will measurably enhance the program. Throughout these deliberations, the members and staff of the Subcommittee on Health and Scientific Research participated in an open and active dialog with officials at the Department of Health, Education, and Welfare, representatives of planning agencies, the health industry, consumer groups, labor unions, and the business community.

These proceedings have brought to the committee's attention a number of problem areas which S. 2410 as reported is intended to redress. Numerous complaints were received that, despite the law's mandate for a consumer majority on HSA and other planning bodies, consumers remained at a disadvantage in challenging the community influence and technical information wielded by health care providers. In some cases the complaints centered around the lack of education and staff support for consumer board members. In other cases, it was charged that sincere efforts had not been made to attract representatives of low-income or medically underserved groups, or that the selection process for board members had not been sufficiently well publicized or had resulted in self-perpetuating boards dominated by provider interests.

Concern was expressed by mental health authorities that the health planning structure was not well coordinated with the mental health planning systems developed throughout the State and localities and that mental health in general had not been given appropriate emphasis in the original legislation. Similar concerns were felt by alcohol and drug abuse authorities, area agencies on aging and the rate review programs operative in many States.

Planning agencies in general urged the committee to increase overall funding levels to keep pace with the current rate of inflation and to recognize the necessity for additional funds as the program assumes

new and broader responsibilities, particularly in the area of hospital cost containment. Special attention was drawn to the unusual financial burdens of HSA's which serve more than one State or a large sparsely populated area or areas with large rural or urban medically underserved populations.

Speaking on behalf of the Nation's Governors, the National Governors' Association requested the committee to give the Governor, as the State's chief executive charged with responsibility for overall State health policy, a more defined and visible role in the finalization of the State health plan and the State medical facilities plan, which together act as the planning document for health services throughout the State and the foundation on which certificate-of-need decisions are to be based. Problems which had arisen of the splitting of standard metropolitan statistical areas (SMSA's) particularly in multi-State areas were also of concern to the Governors. The current process of redesignation of health service area boundaries was also called into question by the Governors, who felt it had proved to be unwieldly and unnecessarily restrictive.

Organizations such as the National Association of Counties recommended that the committee reassign responsibilities now accorded to the separate governing body for health planning in public HSA's to the parent governing body, on grounds that this provision in Public Law 94–641 had left little authority or responsibility for the parent governing body legally liable for the actions and decisions of separate health planning body. In a related matter, a recent Montgomery County, Md., lawsuit has successfully challenged the entire concept that HSA's that are a unit of local government must have a separate governing body for health planning.

With regard to the certificate-of-need program, one of the most critical problems involves a major loophole in the present law which allows certain individuals, primarily physicians, not presently subject to certificate-of-need to purchase very expensive medical equipment for which hospitals or other institutions subject to review have been denied approval. There is a widespread fear that exemption of noninstitutional providers has already led to a vast proliferation of high-cost technology, such as CAT (computerized axial tomography) scanners, with an enormous potential for improper or overutilization and a consequent increase in costs throughout the health system. While planning agencies have reportedly been increasingly successful in controlling the construction of new hospital beds, they have been noticeably less stringent in their review of new major medical equipment.

The publication of the national health planning guidelines brought to public attention a growing national problem stemming from an oversupply of hospital beds. It has been estimated that nationwide there may be as many as 100,000 unneeded hospital beds costing well over $2 billion a year. The guidelines called for planning agencies to use 4 hospital beds per 1,000 population and minimum occupancy levels of 80 percent as benchmarks on drawing up their health plans assessing the need for both new and existing resources in their respective health service areas. While some mistakenly feared that the guidelines thereby mandated HSA's to close unneeded existing facilities and beds, others correctly appreciated that hospital overcapacity was eroding efforts to control overall hospital costs. Proposals to expand HSA and

State Agency authority to include decertification of unneeded facilities met with mixed reaction during hearings conducted by the Subcommittee on Health. However, there was almost unanimous support for some type of effort to encourage hospitals voluntarily to close or convert unneeded facilities.

In drafting and revising S. 2410, the committee has considered thoroughly all the viewpoints presented at hearings and through written submission. The committee adheres to the basic belief that the planning process as envisioned in Public Law 93–641 can work and has therefore attempted to strengthen this process—not disrupt it. The committee recognizes that the process has been full of turmoil for those involved in planning for health care. It has taken more time than was anticipated for the network of health systems agencies, State health planning and development agencies, and statewide health coordinating councils to be fully organized and functioning. The Department of Health, Education, and Welfare has been negligently slow in promulgating the required regulations. Its efforts have been further slowed by the amount of litigation which has challenged the act's constitutionality and other provisions.

III. Detailed Description of Current Health Planning Law (Public Law 93–641)

The National Health Planning and Resources Development Act of 1974 was composed of two principal parts. The first added a new title XV in the Public Health Service Act—National Health Planning and Development—as a replacement for previous health planning initiatives authorized under the regional medical program and the comprehensive health planning program. The second, a new title XVI in the PHS Act for health resources development, was intended as a replacement in large part for the Hill-Burton medical facilities construction program. Although the Hill-Burton program (under title VI of the PHS Act) was not actually repealed and its requirements pertaining to facilities funded under its authority were to remain in effect, the new title XVI program was to be the conduit for future allocation of Federal funds for construction, modernization, and conversion of health facilities.

Part A of the new title XV established a National Council on Health Planning and Development, and also directed the Secretary of HEW to issue national guidelines for health planning. Part B of the new title created a system of health systems agencies (HSA's) responsible for areawide health planning and development throughout the country. Part C of the title provided assistance to State governments in the development and funding of State health planning and development agencies (SHPDA's). Part D contained general provisions applicable to the above programs, including authorization for 10 regional centers for health planning. Parts A, B, C, and D of the new title XVI revised the program of State allotments, loans and loan guarantees, and special project grants for health facilities construction, modernization, and conversion. Part E of the new title XVI contained general provisions relating to the foregoing programs. Part F provided area health services development funds to HSA's for their use in development of health resources designed to implement their health plans.

National Guidelines for Health Planning

The law directed the Secretary of HEW to issue, within 18 months of enactment, guidelines concerning national health planning policy and to revise such guidelines as deemed appropriate. In issuing guidelines, the Secretary was to include standards respecting the appropriate supply, distribution, and organization of health resources and a statement of national health planning goals expressed to the maximum extent practicable in quantitative terms. Recommendations and comments were to be solicited from HSA's, SHPDA's Statewide Health Coordinating Councils, associations and specialty societies representating medical and other health care providers, and the National Council on Health Planning and Development (sec. 1501).

National Health Priorities

The law contained a statement of Congressional findings that the following considerations deserve priority in the formulation of national health planning goals and in the development and operation of Federal, State, and area health planning and resources development programs:

(1) Provision of primary care services for medically underserved populations, especially those located in rural or economically depressed areas;

(2) Development of multi-institutional systems for coordination or consolidation of institutional health services;

(3) Development of medical group practices, health maintenance organizations, and other organized systems for provision of health care;

(4) Training and increased utilization of physician assistants, especially nurse clinicians;

(5) Development of multi-institutional arrangements for sharing of support services necessary to all health service institutions;

(6) Promotion of activities to achieve needed improvements in quality of health services, including needs identified by professional standards review organizations under title XI of the Social Security Act;

(7) Development by health service institutions of capacity to provide various levels of care on a geographically integrated basis;

(8) Promotion of disease prevention activities, including studies of nutritional and environmental factors affecting health and the provision of preventive health care services;

(9) Adoption of uniform cost accounting, simplified reimbursement, and utilization reporting systems and improved management procedures for health service institutions; and

(10) Development of effective methods for general public education about proper personal health care and effective use of available services (sec. 1502).

National Council on Health Planning and Development

The law established in the Department of HEW an advisory council known as the National Council on Health Planning and Development. The Council was charged with responsibility for advising, consulting with, and making recommendations to the Secretary with respect to (1) development of the national guidelines; (2) the implementation and administration of the programs established under the act; and (3) evaluation of implications of new medical technology

for the organization, delivery, and equitable distribution of health care services.

Composition of the Council was to consist of 15 members, with the Chief Medical Director of the Veterans' Administration, the Assistant Secretary for Health and Environment of the Department of Defense, and the Assistant Secretary for Health of the Department of HEW included as nonvoting ex officio members. The remainder were to be appointed by the Secretary to serve for staggered 6-year terms and were to include persons who, as a result of their training, experience, or attainments, were exceptionally well qualified to assist in carrying out the Council's functions. Not less than five were to be persons who were not health care providers, not more than three were to be Federal employees, not less than three were to be members of HSA governing bodies, and not less than three were to be members of Statewide Health Coordinating Councils (SHCC's). In addition, the two major political parties were to be equally represented. Voting members were to select a chairman from among their number. Council members were to be compensated and allowed to appoint, fix the pay of, and prescribe the functions of supporting staff. In addition, the Council could utilize the services of experts and consultants (sec. 1503).

Health Service Areas

The law provided for the designation by the Governors of health service area boundaries for which health systems agencies were to be designated. The conference report noted that no implementing regulations were required and that the designation process was to begin immediately after enactment of the act.

Health service areas were to be geographic regions appropriate for the effective planning and development of health services, determined on the basis of such factors as population and the availability of resources to provide all necessary health services for area residents. To the extent practicable, the area was to include at least one center for provision of specialized health services. A health service area could encompass a maximum population of 3 million except in areas which included a standard metropolitan statistical area (SMSA) of more than 3 million. The minimum population size for an area was to be 500,000 except that it could go down to 200,000 in unusual circumstances and below 200,000 in highly unusual circumstances. To the maximum extent feasible, the area was to be coordinated with other relevant existing geographic areas including professional standards review organization areas and existing regional planning and State planning and administrative areas.

The boundaries were to be established so as to recognize the differences in health planning and resources development needs between nonmetropolitan and metropolitan areas, and to take into account any economic or geographic barrier to receipt of services in nonmetropolitan areas. Each SMSA was to be entirely contained within the boundaries of one health service area unless, with the Secretary's approval, the Governor of each State in which an SMSA was located determined otherwise.

Boundaries were to conform to those of the preexisting 314(b) comprehensive health planning agencies if the areas encompassed by these former agencies met the designation requirements. The Governor

could waive this requirement if he found that another area was more appropriate for effective planning and development of health resources.

The law detailed the procedures to be followed in the designation process. The areas proposed by the Governors were to serve as the official boundary designations unless they were inconsistent with the law's requirements or did not include a portion of the United States. In such instances, the Secretary was given authority to make necessary changes. The initial designation process for all States (except those specifically exempted under section 1536) was to be completed by January 4, 1976.

The appropriateness of boundary designations was to be reviewed by the Secretary on a continuing basis. Revisions could be initiated either by the Secretary, the Governor, or designated health systems agencies, but revisions could only be made (after consultation with Governors and appropriate agencies) if the Secretary determined that the boundary no longer met the specified requirements (sec. 1511).

Health systems agencies

The law provided for the creation of a nationwide network of health systems agencies (HSA's) responsible for areawide or regional health planning and resources development in their respective health service area. Health systems agencies could be either nonprofit private corporations or public entities. A nonprofit private corporation (or similar legal mechanism) was required to:

(1) Be incorporated in the State in which the largest part of the population of its health service area resided;

(2) Not be a subsidiary of or otherwise controlled by another public or private entity; and

(3) Only engage in health planning and development functions.

A public entity could be either: (A) A single unit of general local government if its area of jurisdiction was identical to that of the applicable health service area, or (B) a public regional planning body which had a planning area identical to the health service area and either had a governing board (the majority of whom were elected local officials) or was authorized by State law (in effect prior to the enactment) to carry out requisite health planning and review functions. Health systems agencies could not be or operate an educational institution.

HSA's were to employ staff who possessed expertise in administration, gathering and analysis of data, health planning, and development and use of health resources. The functions of planning and development of health resources were to be conducted by staffs with skills appropriate to each function. Each HSA was to have a minimum staff of five professionals, or one professional (up to a maximum of 25) for every 100,000 persons in the area, whichever was greater. Methods for selection, compensation, promotion, and discharge of staff members were to be determined by each agency, with the stipulation that pay for any position be at least that for comparable positions in the area. The agency could also employ consultants and contracts with individuals or entities for the provision of services.

Public HSA's were required to have a separate governing body for health planning with exclusive authority to perform the requisite

planning functions. Private HSA's were required to have a governing body composed of 10–30 members. The number could exceed 30 if the governing body established an executive committee (composed of up to 25 members of the full governing body) which had been delegated authority assigned to the governing body (except for the preparation of health plans).

The governing body was given responsibility for the internal affairs of the agency, establishment of a health system plan (HSP) and annual implementation plan (AIP), approval of grants and contracts awarded to implement these plans, approval of actions taken pursuant to agency review functions, issuance of an annual report, and additional functions relating to its operation. The governing body could act only upon a majority vote of its members at a meeting called upon adequate notice at which a quorum (50 percent) of its members was present.

Consumers were to fill a majority (but not more than 60 percent) of the membership positions on the governing body and executive committee. The remaining members were to be health care providers residing in the area who represented health professionals (including physicians, particularly practicing physicians, dentists, nurses, and others); health care institutions (particularly hospitals, long-term care facilities, and health maintenance organizations); health care insurers; health professional schools; and the allied health professions. At least one third of the provider members were required to be direct providers of health care, as opposed to indirect providers defined elsewhere in the act as individuals:

(1) Holding a fiduciary position with, or fiduciary interest in entities engaged in provision of health care or in such research or instruction, or entities engaged in drug manufacture;

(2) Receiving (either directly or through one's spouse) more than one-tenth of gross annual income from research or instructions in or provision of health care, or from manufacture of drugs or other articles used in health care;

(3) Who are members of the immediate family of a direct or indirect provider; or

(4) Employed by health insurers.

Membership was to include (either through consumer or provider members) public elected officials, other representatives of local governmental authorities, representatives of local public and private health agencies, and a proportional percentage of residents of the nonmetropolitan areas within the service area. Where the health service area included a hospital or other health facility of the Veterans' Administration or a qualified health maintenance organization, HSA membership was to include representatives of such entities, in the case of the VA representative on an ex officio basis. Any subcommittees or advisory groups appointed by the governing body or executive committee were to be composed to the extent practicable in a similar manner.

Consumer members were to be residents of the health service area who were not (nor within the 12 months preceding appointment had not been) providers and who were broadly representative of the social, economic, linguistic, and racial populations, geographic areas of the health service area, and major purchasers of health care.

The law provided that members or employees of HSA's were to be exempt from civil liability in the performance of their functions, provided such individuals had acted within the scope of their responsibilities, exercised due care, and acted without malice.

HSA's were precluded from accepting funds or other contributions of facilities or services from individuals or entities with a financial or other direct interest in the development, expansion, or support of health resources. Agencies were permitted to accept contributions from charitable foundations such as those described in section 509(a) of the Internal Revenue Code of 1954, provided such entities were not directly engaged in the provision of health care in the area.

Health systems agencies were required to make reports and keep records as required by the Secretary; provide for such fiscal control and fund accounting procedures as he might require; and permit the Secretary and Comptroller General access to records and documents.

Subarea councils meeting the composition requirements for HSA's could be established by the HSA to advise the governing body on performance of its functions (sec. 1512).

Functions of health systems agencies

The primary responsibility of each HSA was the provision of effective health planning for its health service area and the promotion of the development of services, manpower, and facilities which met identified needs, reduced documented inefficiencies, and implemented the health plans of the agency. HSA's were to undertake this responsibility in order to: (A) Improve the health of area residents; (B) increase accessibility (including overcoming geographic, architectural and transportation carriers), acceptability, continuity, and quality of health services: (C) restrain increases in the cost of health services; and (D) prevent unnecessary duplication of health resources. To meet this responsibility, each agency had to perform specified functions.

Each agency was required to collect and analyze health data for its area utilizing wherever possible existing data. After consideration of this data, national guidelines for health planning, and national health priorities, the agency was required to establish, annually review, and revise as necessary a health systems plan (HSP). Each HSP was to be a detailed statement of goals: (A) describing a health system which would assure availability and accessibility of quality health services, continuity of care, and reasonable cost of services, (B) responsive to the unique needs and resources of the area, and (C) which took into account and was consistent with the national guidelines. The agency was required to conduct a public hearing prior to establishing the HSP.

As an adjunct to the HSP, the agency was also required to establish an annual implementation plan (AIP) describing objectives to achieve the goals of the HSP and priorities among these objectives. It was also required to develop and publish specific plans and projects to achieve these objectives.

In implementing its HSP and AIP, each health systems agency was required to perform the following functions:

(1) Implement plans to the extent practicable with the assistance of individuals and public and private entities in the area;

(2) Provide, in accordance with AIP priorities, technical assistance to achieve health system described in the HSP; and

(3) In accordance with AIP priorities, make grants to public and nonprofit private entities and enter into contracts with individuals and public and nonprofit private entities for planning and developing projects and programs to achieve the health system described in the HSP. Grants and contracts were to be made from the Area Health Services Development Fund. The money could not be applied toward the costs incurred in delivering health services or the construction or modernization of facilities. Grants and contracts were limited to a 1-year period, with each individual or entity eligible for a maximum of two awards for any project or program.

Each agency was required to coordinate its activities with, secure appropriate data from, to the extent practicable provide technical assistance to, and enter into agreements with professional standards review organizations (under section 1152 of the Social Security Act), and other appropriate general or special purpose regional planning or administrative agencies or other appropriate entity.

Each HSA was given responsibility to review and approve or disapprove the proposed use within its area of Federal funds under the Public Health Service Act, the Community Mental Health Centers Act, and the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 for grants, contracts, loans or loan guarantees for the development, expansion, or support of health resources. Such review was to extend to Federal funds made available by the State from an allotment to the State under the programs mentioned above. Review of funds for grants or contracts under titles IV, VII, or VIII of the PHS Act was restricted to projects involving development of health resources intended for use in the area or for the delivery of health services. The HSA was also required to inform Indian tribes of the availability to Federal funds; however, it could only review and comment on the proposed use of Federal funds located within certain Indian areas.

The agency was given 60 days to make the required review. If an agency were to recommend disapproval of proposed expenditures, the Secretary could not make funds available until he had made, upon request of the entity making the proposal, a review of the agency decision. In reviewing this decision, the Secretary was to give the appropriate State health planning and development agency (referred to as the State agency) opportunity to consider the decision and submit its comments to the Secretary. After taking these comments (if any) into consideration, the Secretary could decide to make the Federal funds in question available for the proposed use. Each decision to make funds available despite an agency's disapproval was to be submitted to the agency and the State agency together with a detailed statement of the reasons.

Each health systems agency was required to review and make recommendations to the State agency respecting the need for new institutional health services. These findings were to be used by the State agency in making findings as to the need for such services.

Each health systems agency was required to review, at least every 5 years, all existing institutional health services and make recommen-

dations to the State agency respecting the appropriateness in the area of such services. After consideration of these recommendations, and a review of all existing institutional health services in the State, the State agency was to publicize its findings. The initial review by the health systems agency was to be completed within three years of its final designation.

Each health systems agency was required to annually recommend to the State agency projects, and priorities among them, for the modernization, construction, and conversion of medical facilities in the area designed to achieve the agency's HSP and AIP (sec. 1513).

Assistance to Entities Desiring to be Designated as Health Systems Agencies

The act authorized the Secretary to provide necessary technical and other nonfinancial assistance to nonprofit private entities which had the potential to become health systems agencies. Such assistance was to include prototype plans of organization and operation. Entities eligible for assistance included existing CHP and RMP agencies (sec. 1514).

Designation of Health Systems Agencies

The act required the Secretary to enter into agreements for the designation of health systems agencies at the earliest date practicable after establishment of health service areas but no later than July 1976. In considering applications for conditional or final designation, the Secretary was required to give priority to applications recommended for approval by existing areawide CHP agencies or RMP programs in the area.

The Secretary could initially enter into a conditional designation agreement (not to exceed 2 years) with eligible entities. Prior to entering a conditional designation agreement, the Secretary was required to consult with the Governor of each State in which the health service area was located and with other appropriate State and local officials.

During the period of conditional designation, the Secretary could require that the HSA meet only certain organizational and operational requirements and perform only certain limited functions. The number and type of requirements and functions would be progressively increased, so that by the end of the period, the entity could be considered for final designation.

The Secretary could enter a final designation agreement with an entity once he determined it to be capable of fulfilling the full range of requirements and functions. The Governor of each State was to be consulted regarding the proposed final designation of an HSA in his State. The period of a final designation agreement was 1 year. The agreement could be renewed if the agency was performing its functions satisfactorily and still met the organizational and operational requirements.

Conditional designation agreements could be terminated upon 90 days notice by either the Secretary or the HSA. Final designation agreements could be terminated at such time and upon notice by either party, as prescribed by regulations, except that the Secretary could only terminate such agreements if the agency was not carrying out the provisions of the designation agreement (sec. 1515).

Planning Grants

Each agency was to receive planning grants for compensation of personnel, data collection, and planning and performance of required functions. Funds could also be used for contracts to assist the HSA in performance of its functions, but planing grant funds could not be used for the development or delivery of health services or resources.

The amount of any grant to a conditionally designated health systems agency was to be determined by the Secretary. The amount of a grant to an agency under final designation was based on a rate of 50 cents per capita, up to a maximum of $3.75 million. In addition, the Secretary was authorized to match locally generated funds up to the maximum of 25 cents per capita for the population of the health service area. An agency could not accept funds for matching purposes from any individual or private entity having a financial, fiduciary, or other direct interest in the development, expansion, or support of health resources. In addition, contributions could not have conditions attached to their use. The minimum planning grants for a health systems agency under either a conditional or final designation agreement was set at $175,000.

If the total amount of grants to be made exceeded the total amount actually appropriated for planning grants for a particular fiscal year, the amount for each health systems agency was to be proportionately reduced. Under these conditions, no agency could receive less than $175,000 unless enough money had not been appropriated to make even this minimum level grant to each agency.

The law authorized $60 million in fiscal year 1975, $90 million in fiscal year 1976, and $125 million in fiscal year 1977 (sec. 1516).

Designation of State health planning and development agencies

Public Law 93–641 provided for the establishment in each State of a State health planning and development agency (State agency) selected by the Governor and designated by the Secretary. Prior to designation of the State agency, each State was to submit to the Secretary an approved State administrative program for performance by the agency of State health planning and development functions. An application for designation had to contain assurances satisfactory to the Secretary, that the agency selected by the Governor had the authority and resources to administer the State's administrative program to conduct the requisite health planning and development functions.

The Secretary could initially enter a conditional designation agreement (for a period not to exceed 2 years) with the Governor of a State. Such agreement had to include a plan, submitted by the Governor, for the orderly assumption of required functions. During the period of conditional designation, the State agency could be required to perform only those functions the Secretary deemed it capable of performing. The number and type of such functions would be progressively increased so that by the end of the period the State agency could be considered for final designation.

The Secretary could enter a final designation agreement with a Governor, if he determined the agency to be capable of fulfilling the full range of required responsibilities.

A final designation agreement was to be for a 1-year period. It could be renewed if the State agency was fulfilling its responsibilities in a

satisfactory manner and if the State administrative program still met specified requirements.

Conditional designation agreements could be terminated upon 90 days' notice by either the Secretary or the State agency. Final designation agreements could be terminated at such time and upon such notice by either party as prescribed by regulations, except that the Secretary could only terminate such agreements if the State agency was not complying with or effectively carrying out the terms of the agreement. If a conditional or final designation agreement was terminated prior to its expiration, the Secretary could, in accordance with the requisite procedures, enter into another agreement with the Governor for designation of a State agency.

The law provided a sanction against States which failed to comply with requirements for final designation of a State agency. If a designation agreement was not in effect by October 1, 1980, the Secretary could withhold Federal funds (in the form of grants, loans, loan guarantees, or contracts) under the PHS Act, the Community Mental Health Centers Act, or the Alcoholism Act for the development, expansion, or support of health resources until such time as an agreement was in effect (sec. 121).

State administrative program

Prior to entering a designation agreement, the Secretary had to approve a State administrative program submitted by the Governor. Prior to submission, the Governor was to afford the general public reasonable opportunity for a presentation of views.

The law required the State program to:

(1) Specify that the State health planning and development agency was the sole agency for performing State health planning and development functions (except when delegated to another agency) and for administration of the State program;

(2) Contain or be supported by evidence that the State agency had the authority under State law to carry out the prescribed functions and contain a current budget for the agency;

(3) Provide for consultation with and authority for the Statewide Health Coordinating Council;

(4) Set forth qualifications for personnel and provide for administration of State program. The State agency was required to have a professional staff for planning and a professional staff for development. The program had to provide for methods relating to establishment and maintenance of personnel standards on a merit basis consistent with standards established by the Civil Service Commission; however, the Secretary could not exercise any authority with respect to selection, tenure, or compensation of any individual employed in accord with these methods;

(5) Require performance of functions by State agency in accordance with procedures and criteria established and published by it;

(6) Require the State agency to conduct business meetings in public, give adequate notice to the public, and make available records and data upon request;

(7) Provide for coordination with existing cooperative systems for data collection and analysis and require health care providers to make appropriate reports to the agency;

27-409 O - 78 - 2

(8) Provide for annual evaluation of agency performance;

(9) Provide for agency review, at least annually, of the State program;

(10) Provide for agency reports to Secretary and maintenance of records;

(11) Require the agency to provide for fiscal control and fund accounting procedures for Federal funds received under the program;

(12) Permit the Secretary and Comptroller General access to records for audit and examination purposes; and

(13) Provide that if the agency, in performance of specified review and certification functions, made a decision inconsistent with the recommendations of a health systems agency, such decision would (at the request of the HSA) be reviewed by another agency of the State. The decision of the reviewing agency would be considered, for purposes of title XV and XVI, the decision of the State agency.

The Secretary was required to approve any State program which met these requirements. He was further required to conduct annual reviews of the specifications and operations of the State program (sec. 1522).

State health planning and development functions

The law set forth the following functions to be performed by the State health planning and development agency (or its designee, in cases where these functions had been delegated upon request of the Governor to another State agency under an agreement satisfactory to the Secretary):

(1) Conduct the health planning activities of the State and implement appropriate parts of the State health plan (prepared by the statewide health coordinating council (SHCC)) and the plans of the HSA's;

(2) Prepare and revise as necessary, but at least annually, a preliminary State health plan which would be a synthesis of HSP's of the health systems agencies. The preliminary State health plan was to be submitted to the statewide health coordinating council for its use in preparing the State health plan;

(3) Assist the SHCC in review of the State medical facilities plan required under the new title XVI, and in the performance of its functions generally;

(4) A. Serve as the designated planning agency of the State purposes of section 1122 of the Social Security Act, in those States which participated in the 1122 program.

(4) B. Administer the State certificate of need program which would apply to new institutional services proposed to be offered or developed in the State;

(5) Make findings as to the need for new institutional services proposed to be offered in the State after consideration of recommendations made by HSA's; and

(6) Review on a periodic basis (at least every 5 years) existing institutional health services, and after consideration of recommendations made by HSA's, make findings public. The first review had to be completed within one year after receiving comments from a health systems agency.

The mandatory certificate of need program (which had to be satisfactory to the Secretary) was to provide for review and determination of need prior to the time services, facilities, and organizations were offered or developed or substantial expenditures undertaken in preparation for such offering or development. The program was to assure that only those services found to be needed would actually be offered or developed. In administering the State's certificate-of-need program and serving as the section 1122 planning agency, the State agency was to consider recommendations of the health systems agencies. States were given one State legislative cycle to institute the requisite certificate-of-need program.

If a State agency were to make a decision in carrying out its review functions which was inconsistent with the HSP or AIP of a health systems agency, it was required to submit a detailed statement to such agency (sec. 1523).

Statewide Health Coordinating Council

The law provided that each State health planning and development agency would be advised by a statewide health coordinating council (SHCC). The SHCC was to have at least 16 representatives appointed by the Governor from lists of at least five nominees submitted by each health systems agency falling in whole or in part within the State. Each agency was entitled to at least two representatives (at least half of whom were consumers) and each agency was to be equally represented. The Governor could appoint additional representatives (at least half of whom were consumers) who could constitute up to 40 percent of the total membership. At least one-third of the provider members had to be direct providers of health care. An appointee of the Veterans' Administration was to serve as an ex officio member in States with two or more VA facilities. The SHCC was required to select its own chairman, hold all business meetings in public, and meet at least four times a year.

The SHCC was directed to review annually and coordinate the HSP and AIP of each health systems agency and report its comments to the Secretary for purposes of his review of the health systems agencies. The SHCC was also directed to prepare and review, and revise as necessary (at least annually), a State health plan using the preliminary plan prepared by the State agency as a draft. The SHCC was to conduct a public hearing on this proposal and subsequently prepare the final plan including any necessary revisions to the HSP's of the health systems agencies. Each health systems agency was required to make available it HSP for intergration into the State health plan and to revise such HSP as required.

The SHCC was to review the budget of each health systems agency within the State annually, review applications by HSA's for planning and development funds, and forward its comments to the Secretary.

In addition, the SHCC was required to advise the State agency on the performance of its functions and annually review and approve or disapprove any State plan and any application submitted to the Secretary as a condition for receipt of any funds under allotments made to States under the PHS Act, the Community Mental Health Centers Act, and the Alcoholism Act.

If a SHCC were to disapprove an application for Federal funds, the Secretary could not make such funds available until he had com-

pleted a review of the SHCC recommendations upon request of the Governor of the State. If following his review, the Secretary approved the application notwithstanding the recommendation of the SHCC, he was to submit a detailed statement of his resons to the SHCC (sec. 1524).

Grants for State Health Planning and Development

Each designated State agency was to receive a grant from the Secretary for up to 75 percent of its operation costs during the period for which the grant was available for obligation. The State agency was required to expend, in the performance of its prescribed functions, an amount from non-Federal sources equal to the average amount spent by the State in the preceding 3 years for similar purposes.

The bill authorized $25 million in fiscal year 1975, $30 million in fiscal year 1976, and $35 million in fiscal year 1977 (sec. 1525).

Grants for Rate Regulation

The law established a demonstration program to determine the effectiveness of rate regulations. Up to six State agencies under a final designation agreement could receive grants if they were currently regulating rates or had indicated their intent to regulate rates prior to July 4, 1975. State agencies receiving assistance were required to provide assurance that they had authority to conduct this function. They were also required to provide the Secretary with a current budget, set forth personnel criteria, have a rate regulation staff headed by a Director, provide for necessary methods of administration, and perform functions in accord with procedures established and published by it. In addition, they were to comply with appropriate requirements of the State administrative program for purposes of rate regulation. The State agency was to establish a procedure whereby it would obtain the recommendation of the appropriate health systems agency prior to conducting a rate review.

The Secretary, in prescribing requirements for State agencies, was required to consider whether the agencies should:

(1) Permit providers to retain savings accruing from effective management;

(2) Create incentives for economical utilization of services;

(3) Document the need for and cost implications of new services; and

(4) Employ for each class or type of provider a unit for dedetermining reimbursement rates and a base for determining rates of change of such rates.

Grants for rate regulation were to be made made on such terms and conditions as the Secretary prescribed. A grant was to be made for a 1-year period with a maximum of three such grants awarded to a State agency.

Each State agency receiving a grant was required to make an annual report to the Secretary. The Secretary was then to report annually to Congress on the effectiveness of rate regulation.

The bill authorized $4 million for fiscal year 1975, $5 million for fiscal year 1976, and $6 million for fiscal year 1977.

General Provisions: Definitions

This section of the law set forth definitions of terms as they applied to the program established by title XV. Included were definitions of

"State," "Governor," "provider of health care" (including both direct and indirect providers as noted earlier in section 1512), "health resources," and "institutional health services." It should be noted that the last term, "institutional health services," was defined as services provided through both health care facilities and health maintenance organizations.

Procedures and Criteria for Reviews of Proposed Health System Changes

In reviewing proposed use of Federal funds or the need for proposed or existing health services, each health systems agency (and each State agency in performing its mandated review functions) was required to follow procedures and apply criteria developed and published by it in accord with regulations issued by the Secretary. Such procedures and criteria could vary according to the purpose for which the review was conducted or the type of service being reviewed.

The law specified the procedural activities to be performed during reviews and enumerated a number of substantive considerations to be taken into account during the review process. Among the various procedural stipulations were the following requirements: advance written notification to affected persons, a 90-day maximum review period, provision for written findings on decisions, notification of providers and others of findings made in the course of review, provision for public hearings if requested by affected parties, public access to all written materials pertinent to review, and letters of intent to be submitted by entities proposing projects detailing the scope and nature of projects.

Criteria for review were to include at least the following: Relationship of health services under review to the applicable HSP, AIP, long-range development, the existing health care system, and the plan of the person providing or proposing such services; the need for such services; availability of less costly or more effective alternatives; availability of resources; special needs and circumstances of entities providing a substantial portion of their services or resources to individuals not residing in the health service area (such as health professions schools, multidisciplinary clinics, specialty centers) ; special needs and circumstances of health maintenance organizations; for construction projects, the costs and methods of proposed construction and probable impact on costs of providing health services (sec. 1532).

Technical assistance for health systems agencies and State health plannning and development agencies

The Secretary was required to provide (directly or through grants or contracts) technical assistance to health systems, agencies, and State agencies. The materials were to include specification of minimum data needs; planning approaches, policies, and standards consistent with the national guidelines for health planning and covering specified national health priorties, and guidelines for organization and operation of the health systems agencies and State agencies.

The Secretary was directed to establish a national health planning information center (NHPIC) to support health planning and resources development programs and to provide information.

The Secretary was to establish the following prior to January 4, 1976: a uniform system for calculating the aggregate cost of operation and the aggregate volume of services provided by health service

institutions; a uniform system for cost accounting and calculating the volume of such services; a uniform system of calculating rates to be charged to health insurers and other health institutions payors by health service institutions; a classification system for health services institutions; and a uniform system for reporting of costs, volume of services, and rates of such institutions (sec. 1533).

Centers for health planning

The law provided authority for the creation of regional centers for health planning to provide technical and consulting assistance to HSA's and State agencies. The Secretary was to make grants or contracts to public or private nonprofit entities to meet costs of planning and developing such centers. To the extent practicable, at least five centers were to be in operation by June 30, 1976. Although not spelled out in the law, the intent was for a center to be located in each HEW region. Centers were required to have a full-time director knowledgeable in health planning and resources development and additional professional staff representing a diversity of relevant disciplines. Centers could arrange with HSA's and State agencies to provide necessary services and were required to disseminate to them the planning approaches, methodologies, policies, and standards they developed.

The law authorized $5 million for fiscal year 1975, $8 million for fiscal year 1976, and $10 million for fiscal year 1977 (sec. 1534).

Review by the Secretary

The law required the Secretary to review and approve or disapprove (after consideration of the comments of the SHCC) the annual budget of each designated health systems agency. The requirement extended to submission, upon request, or relevant review material to appropriate congressional committees.

The Secretary was directed to establish performance standards covering the structure, operation, and performance of required functions of each health systems agency and each State agency. A reporting system based on these performance standards was mandated to allow for continuous review. At least every 3 years, the Secretary was to review in detail the structure, operation, and performance of each HSA and each State agency. The review was to include a determination of whether the requirements of law had been met; the adequacy of the appropriate health plan; the professional credentials and competence of the staff; and the extent to which improvements had been made in health status and health delivery and the extent to which cost increases had been restrained. The review ofa health systems agency was also to include a determination of the representative character of the governing body, the appropriateness of data and quality of its analysis, and extent to which technical and financial assistance provided the agency had been restrained. The review of a health systems agency was also to operations was to include a performance review of the SHCC and a determination of the extent to which financial assistance provided under the new health resources development program (title XVI) had been used effectively to achieve the State's health plan (sec. 1535).

Special provisions for certain States and territories

An State which had successfully operated a statewide health planning system which substantially complied with the purposes of the act

and which had no county or municipal public health institutions or departments could apply for a waiver from the requirements for health service areas and health systems agencies. The State agency could perform the prescribed functions and be eligible for planning and development grants. The Governor was to appoint the members of the SHCC in accordance with regulations issued by the Secretary.

The statute specifically provided this exemption for the Virgin Islands, Guam, the Trust Territories in the Pacific Islands, and American Samoa (sec. 1536).

Health resources development

Public Law 93–641 added a new title XVI, "Health Resources Development" to the Public Health Service Act. The new title provided Federal assistance for construction and modernization projects for specified purposes and authorized grants to health systems agencies for establishment and maintenance of area health services development funds.

Federal assistance through allotments, loans, and loan guarantees (with interest subsidies) was provided for projects for:

(1) Modernization of medical facilities;

(2) Construction of new outpatient medical facilities;

(3) Construction of new inpatient medical facilities in areas (as determined under the Secretary's regulations) which had experienced recent rapid population growth; and

(4) Conversion of existing medical facilities for the provision of new health services.

In addition, the measure authorized special project grants for projects designed to prevent or eliminate safety hazards in medical facilities or to avoid noncompliance by such facilities with licensure or accreditation standards (sec. 1601).

General regulations

The Secretary was required to issue regulations prescribing the general manner in which the State agency would set priorities among projects based on the relative needs of different areas and special considerations defined in law. He was also required to prescribe:

(1) General standards of construction, modernization, and equipment;

(2) Criteria for determining needs for facilities and beds and need for modernization of facilities;

(3) Requirements that each State medical facilities plan provide adequate medical facilities for all State residents and facilities for services to persons unable to pay.

(4) The general manner in which an entity receiving assistance would be required to comply with required assurances and demonstrate compliance.

Such entities were required to submit periodically to the Secretary data and information which reasonably supported the entity's compliance (sec. 1602).

State medical facilities plan

Before any application for Federal assistance under title XVI (except for special project grants) could be approved, the State agency would have to submit (and have approved by the Secretary) a State

medical facilities plan. The Secretary was required to approve this plan if:

(1) It contained the items prescribed by law; and

(2) The State agency (as determined by his review) was organized and operated and performing the functions prescribed under title XV.

The State agency was entitled to a hearing if any plan or modification thereof was disapproved by the Secretary for failure to comply with the requirements of law.

An approved State plan was required to:

(1) Prescribe that the State agency would administer or supervise the administration of the plan and contain evidence that it has authority to do so.

(2) Prescribe that the SHCC would advise and consult with the State agency in carrying out the plan.

(3) Be approved by the SHCC as consistent with the State health plan developed by it.

(4) Set forth (in accordance with the Secretary's regulations) an assessment of need for inpatient and outpatient services and facilities and need for modernization or conversion of existing facilities. The assessment would be based on a statewide inventory of existing facilities, a survey of need, and plans of health system agencies.

(5) Set forth a State program of assistance in conformance with the assessment of need indicating type of assistance which should be provided each project.

(6) Set forth, in accordance with regulations, priorities for projects in accordance with the assessment of need.

(7) Provide minimum requirements (fixed at the discretion of State agency) for maintenance and operation of facilities receiving assistance and for enforcement of these standards.

(8) Provide all applicants for assistance with opportunity for a hearing before the State agency.

(9) Provide for review (at least annually) of plan and submission of modifications to Secretary (sec. 1603).

Approval of Projects

Receipt of Federal project assistance was contingent upon submission of an application to the Secretary through the State agency. The applicant could be a State, political subdivision of the State or other public entity, a nonprofit private entity, or a combination of these. Applications for special project grants were to be submitted directly to the Secretary by a State or political subdivision of the State. Each application was to be reviewed by the health systems agency in accordance with requirements for review of proposed use of Federal funds.

Among the items to be included in the application were the following: a finding of need by the State agency, description of the project site, reasonable assurance that adequate financial support would be available for project completion and subsequent operation, certification of Federal share for project (except for special project grants), and assurances regarding compliance with labor standards. Applications for construction or modernization of an outpatient facility were

to contain assurances that general hospital services would be available for patients requiring such care. All applications were also to provide reasonable assurances that:

(1) The facility or portion thereof receiving assistance would be available to all persons residing or employed in the area; and

(2) There would be made available in such facility or portion thereof a reasonable volume of services (as determined by the Secretary taking into consideration financial feasibility) for persons unable to pay for them.

The law included special provisions in the case of an application for a modernization project for an outpatient facility which would provide general purpose health services, which was not part of a hospital, which would serve a medically underserved population, and for which not more than $20,000 was sought for allotments or loans. For such projects the Secretary could waive requirements respecting modernization and equipment standards and title to project site.

The Secretary was required to approve a project application for allotments or loans or loan guarantees if application was in conformance with the State medical facilities plan, had been recommended and approved by the State agency, was entitled to priority over other projects in the State (as determined in accordance with the medical facilities plan) and contained the necessary assurances. In addition, applications for allotments could not be approved unless there were sufficient funds in the allotment to pay the Federal share.

No project application for allotments or loans and loan guarantees could be disapproved until the State agency had been afforded an opportunity for a hearing (sec. 1604).

Allotments

Allotments among the States for project money was to be made by the Secretary each fiscal year on the basis of population, financial need, and need for medical facilities projects of the respective States. The minimum allotment for any State was set at $1 million, except that the minimum allotment for Guam, American Samoa, the Virgin Islands and the Trust Territory of the Pacific Islands was to be $500,000. If the total amount appropriated in any fiscal year were insufficient to make the specified minimum allotments, the amount for all States would be proportionately reduced. Allotments were to remain available for obligation for 3 fiscal years except that the Secretary was authorized to reallot unobligated allotments to other States at the end of the second fiscal year after the allotment was made. Such reallotment monies were to be in addition to amounts allotted to the State during the period (sec. 1610).

Payments From Allotments

The Secretary was required to make payments to the State from its applicable allotment for any approved project if the State agency certified (on the basis of its inspection) that in accordance with approved plans and specifications, work had been performed or purchases made and that payment was due.

If an amendment to an application was approved or the cost estimate was revised upward, additional payments could be made from the State's allotment. In no case could the total payments under allotments exceed the Federal share (generally not to exceed two-thirds of

project costs) for the project. No more than 20 percent of a State's allotment could be obligated for construction of new inpatient facilities. Not less than 25 percent of such allotment was to be used for outpatient facilities which would serve medically underserved areas; the Secretary was to seek to assure that these funds were equally divided between urban and rural areas (sec. 1611).

Withholding of Payments and Other Compliance Actions

The Secretary was authorized (after reasonable notice and opportunity for a hearing to the State agency) to withhold payments under allotments if he found that:

(1) The State agency was not in substantial compliance with items required to be included in the State medical facilities plan;

(2) Requisite assurance for an application was not or could not be carried out;

(3) There was substantial failure to carry out the project plans and specifications.

Under these circumstances he could withhold payment in whole or in part from specific projects or all projects in the State for which the finding was made.

The Secretary was periodically required to ascertain compliance by each entity receiving assistance. If he found an entity out of compliance, he could withhold funds or take other appropriate actions. A compliance action would be brought by a person other than the Secretary only if he had dismissed the complaint or the Attorney General had not taken action within 6 months after the complaint was filed (sec. 1612).

Authorization Appropriations

Public Law 93–641 authorized appropriations for allotments of $125 million in fiscal year 1975, $130 million in fiscal year 1976 and $135 million in fiscal year 1977. However, 22 percent of appropriated funds were earmarked for special project grants under section 1625(d) (sec. 1613).

Authority for Loans and Loan Guarantees

The Secretary was authorized for fiscal year 1975–77 to make loans to pay the Federal share (generally not to exceed 90 percent) of the cost of approved projects and to guarantee loans made by non-Federal lenders or the Federal financing bank to nonprofit private entities for such projects. In the case of a guaranteed loan, the Secretary was to pay interest subsidies in an amount sufficient to reduce the effective interest rate by three percentage points. The cumulative total of principal on outstanding guaranteed loans could not exceed limitations specified in appropriation acts. The Secretary, with the consent of the Secretary of the Department of Housing and Urban Development (HUD), was to obtain such assistance from HUD as needed to administer the program (sec. 1620).

Allocation among the States

For each fiscal year, the total amount of principal of guaranteed and direct loans was to be allocated by the Secretary among the States (in accordance with regulations) on the basis of population, financial need and need for medical facilities. Allotments to States were to re-

main available for obligation for 3 fiscal years; if the Secretary determined at the close of the second year that an amount would not be obligated during the period, he could reallot such amounts among the States (sec. 1621).

General provisions related to loan guarantees and loans

The law enumerated requirements including general financing arrangements and conditions applicable for loans and loan guarantees. Loan guarantees could not be made if the interest rate exceeded the prevailing rate or if the loan would otherwise be available on reasonable terms and conditions. Direct loans could not be made unless the Secretary was reasonably satisfied that the applicant would be able to meet the payments and obtain additional funds necessary to complete the project. The interest rate on such direct loans was to be the current prevailing interest rate minus three percentage points.

The act established a loan and loan guarantee fund in the Treasury and authorized appropriations from time to time of such amounts as would be necessary to provide sums required for the fund. To provide additional capitalization for the fund, the law authorized appropriations to the fund of such sums as would be necessary in fiscal year 1975–77 (sec. 1622).

Project grants

The Secretary was authorized to make grants for construction or modernization projects designed to:

(1) Eliminate or prevent imminent safety hazards as defined by Federal, State or local fire, building or life safety codes or regulations; or

(2) Avoid noncompliance with State or voluntary licensure or accreditation standards.

Project grants could be made only to a State or political subdivision (including any city, town, county, borough, hospital district authority, or public or quasi-public corporation) for a project for a medical facility owned or operated by it. Grant applications were to contain assurances that the applicant would not otherwise be able to complete the project.

The amount of any grant could not exceed 75 percent of total project cost except in urban or rural poverty areas where the grant could cover up to 100 percent of the cost. The act required that 22 percent of the funds appropriated for allotments under this title XVI would be earmarked for project grants (sec. 1625).

Judicial review

The law provided for appeal in the appropriate U.S. court of appeals by:

(1) The State Health Planning and Development Agency in the case of a disapproved project application, or

(2) By a State dissatisfied with, or an entity which would be adversely affected by, the Secretary's decision to withhold payments or take other compliance action (sec. 1630).

Recovery

The law provided for the recovery by the United States of its proportionate share of current value of any facility receiving assistance

under this program, if at any time within 20 years after completion of construction, modernization, or conversion, the facility was:

(1) Sold or transferred to any person or entity not qualified to be an applicant under the program or not approved by the State agency as a transferee; or

(2) The facility ceased to be a medical facility unless the Secretary determined there was good cause for such termination.

The Secretary would waive recovery rights if:

(1) The amounts to be recovered were applied to the development, expansion, or support of another medical facility which had been approved by the SHCC; or

(2) The Secretary determined there was good cause for waiving the requirement.

The waiver provisions were restricted to 90 percent of the total cost and the Secretary could not waive recovery rights which arose before January 4, 1973 (sec. 1631).

State control of operations

The law prohibited Federal employees from exercising any supervision or control over the administration, personnel, maintenance, or operation of any facility assisted under this program (sec. 1632).

Definitions

The law defined terms used under title XVI (sec. 1633).

Financial statements; records and audit

Entities assisted under the program were required to keep records and file annual financial statements. The Secretary and Comptroller General were permitted access to records for the purpose of audit. Entities receiving assistance (other than project grants) were further required to file an annual report with the State agency (sec. 1634).

Technical assistance

The Secretary was directed to provide technical and other nonfinancial assistance to entities to assist them in developing applications for assistance. He was also to make every effort to inform eligible applicants of the availability of assistance (sec. 1635).

Development grants for area health services development funds

The Secretary was required to make an area health services development grant in each fiscal year to each health systems agency which:

(1) Was under a final designation agreement;

(2) Had in effect an HSP and AIP reviewed by the SHCC; and

(3) Was organized and operated in the prescribed manner and performing its required functions.

This grant was to enable the agency to establish an Area Health Service Development Fund from which it could make grants and contracts for projects to achieve the health system described in the HSP.

The amount of the development grant (up to a maximum of $1 per capita of the area) was to be determined by the Secretary after taking into consideration the area's population, family income, and supply of health services. No grant could be made to an agency unless it had submitted an approved application.

The law authorized for section 1640 $25 million for fiscal year 1975, $75 million for fiscal year 1976, and $120 million for fiscal year 1977.

IV. Progress in Implementation of the Health Planning Law (Public Law 93–641)

Public Law 93–641 called at the beginning of 1975 for the development over several years of a major new system of social institutions in health care to be responsible for the public planning of the Nation's health care system. In the intervening years, an excellent beginning has been made on the development of this system, and the committee now feels that basic structural mechanisms are in place and ready to be used for the planning of new resources, the control and use of new medical technology, and a variety of related functions. At this time, the committee feels it appropriate to review in detail the progress that has been made thus far in implementing the law. The following discussion makes brief mention of the relevant sections of the law and reviews some of the issues which have arisen since enactment.

National Guidelines for Health Planning

Sec. 1501 of the act requires the Secretary to issue guidelines, by regulation, concerning national health planning policy. The purpose of the guidelines is to help clarify and coordinate national health policy and to assist HSA's in developing required health systems plans. The guidelines are to be more than national statements of values and preferences. Agencies are to examine the relationship between the area's experience and the national goals and standards, and reflect the national priorities in the area's health plans. Agencies will, of course, also deal with important local problems not addressed in the national guidelines.

As noted in the Senate report S. 95–102 on the 1-year extension of the Health Planning Act, considerable delay had been experienced in issuing the guidelines, which the act had called for by a July 4, 1976, deadline. The Committee urged that early and aggressive efforts on the part of the new administration be made to complete the necessary work on the guidelines.

On September 23, 1977, the Secretary published a notice of proposed rulemaking proposing an initial set of national guidelines pertaining to general hospital beds; obstetrical, pediatric, and neonatal special care units; open heart surgery and cardiac catherization units; radiation therapy; computed tomographic scanners; and end-stage renal disease. In publishing the initial set of guidelines, the Department chose to focus on a limited number of issues relating to hospital resources that were felt to present important short-term opportunities for the containment of costs and the enhancement of the quality of care. The Department noted that this initial set of guidelines represented the first segment of what was to become a rational, comprehensive set of health planning goals and standards, addressing such issues as cost containment, access to care, availability and distribution of health care resources, quality of care, and health status. The Department noted that regulations on areas not addressed in the initial set of guidelines would be proposed in the near future.

During the public comment period on the September 23 proposed guidelines, more than 55,000 communications were received by the Department. By and large, those comments were highly critical of both the substance of the guidelines and the process through which they had been developed. Dissatisfaction focused primarily on the following areas: (1) Degree of local control over health planning decisions, (2) potential impacts on rural areas with many small community facilities, (3) scope and emphasis of the guidelines, (4) tendency to encourage unnecessary utilization, (5) premature issuance without sufficient outside consultation, (6) confusion over the role of HSA's in closure of noncompliant facilities, (7) potential for impairment of educational programs conducted by certain institutions, and (8) failure to address the question of services provided through Federal health care facilities.

Public response to the initial guidelines had been overwhelming. Some congressional offices reported receiving as many as 10,000 to 12,000 letters. On November 30, 1977, HEW Secretary Califano sent a letter to Members of Congress clarifying the intent of the proposed guidelines and responding to issues raised in the public comments. Among other things, he noted that neither the act nor the guidelines authorized any HSA, State agency, or the Secretary to close existing hospitals or hospital services. He agreed to clarify and broaden the exceptions applicable to rural and community facilities and the standards proposed for obstetrical units. He also emphasized that nothing in the act or the guidelines was intended to take health planning decisions concerning individual facilities out of local and State hands.

On January 20, 1978, a revised version of the guidelines was published as a notice of proposed rulemaking. In view of the widespread interest in this material, the Secretary had decided it would be desirable to provide an additional 30-day period for public review and comment. During the second comment period, about 900 letters were received, including over 1,700 individual comments. Careful note was made of the extensive process undertaken by the Department following the September 23 publication to secure appropriate consultation and public commentary. During the first comment period, a series of five public meetings had been held by the Department, during which individuals from the fields of medicine, health administration, and consumer interest were actively consulted. Comments and recommendations had also been received as the result of the Department's direct request for the views of all State and local health planning agencies and numerous professional and consumer groups. In revising the initial set of guidelines, efforts had been made to document sources of material used in developing the standards, such as material obtained from the Institute of Medicine, the Office of Technology Assessment, and many national professional associations and organizations involved in setting standards for medical care.

HEW's revised set of proposed standards left intact the proposed general hospital bed ratio of four beds per 1,000 population and the minimum average annual hospital occupancy rate of 80 percent within a health service area. However, the revised guidelines contained a number of revisions to take further account of the special conditions and needs of rural areas, and emphasized the responsibilities of HSA's to make adjustments to take these into account. The new draft relaxed

the numerical standards for rural and smalltown hospitals by broadening the exceptions which could be considered by HSA's when applying standards. In particular, the revised guidelines permitted deviations from the bed ratio and occupancy standards if distance to sources of hospital care exceeded a traveltime factor of 30 minutes (the original standards had set 45 minutes) and if the area's elderly population exceeded 20 percent of the national average (33 percent in the September 23 proposals).

Standards in a number of other areas were also eased, in particular those pertaining to obstetrical services and CAT scanners. The earlier figures had called for 2,000 deliveries annually in a metropolitan area and at least 500 in rural areas. The revised guidelines dropped all mention of numerical standards for deliveries annually, except for hospitals providing care for complicated obstetrical problems which were required to have at least 1,500 deliveries per year. The new draft did retain its earlier figure for average annual occupancy rates of at least 75 percent in each obstetrical unit with more than 1,000 births per year.

Numerical standards for computerized axial tomography (CAT) scanners were changed significantly from a previous level of 4,000 scan procedures annually to a level of at least 2,500 "medically necessary" procedures. The number of scans required before another unit could be approved for acquistion remained, however, at 2,500.

On March 28, 1978, final regulations on the national guidelines were published by the Secretary. They are substantially the same as those published on January 20, 1978. While stopping short of an outright exemption for small rural hospitals (who had felt threatened with imminent closure if application of the standards had been too rigidly imposed by HSA's), the guidelines now specify upward or downward to meet a specific local situation. The revised guidelines reemphasize the important responsibility which HSA's have to analyze and plan how the guidelines apply to local needs and conditions.

National Council on Health Planning and Development

Sec. 1503 of the act mandated the creation of a National Council on Health Planning and Development, responsible for advising and making recommendations to the Secretary concerning national guidelines, implementation and administration of the program, and evaluation of new medical technology. As noted earlier in the report, three members of the Council are ex officio, nonvoting—the Chief Medical Director of the Veterans' Administration, the Assistant Secretary for Health and Environment of the Department of Defense, and the Assistant Secretary of Health of the Department of HEW.

All the remaining 12 members of the Council have now been appointed. The composition of the Council includes four women, three minority representatives (two black, one Hispanic), three physicians (two from private practice, one from a university), one practicing hospital administrator, one professor of health care administration, one health insurance representative, one labor leader, and one from industry. Geographically, the Council is not representative of the Western States. The 12 non-Federal representatives all reside east of the Mississippi.

The Council held five meetings during 1977, all since September 1977, when for the first time since its establishment in November 1975,

the statutorily required membership was complete. The Council now meets monthly to advise the Secretary on development of, and to make recommendations on, revisions of the national guidelines for health planning. This intensive advisory role on the guidelines is expected to continue during 1978 until the Department has published guidelines and regulations on standards and goals related to health status, health promotion, health care, and health financing. According to the Department, the Council's recommendations on revising the national guidelines were immediately considered and incorporated by the staff developing the revised guidelines, the goals and subgoals. Through its public deliberations and the Department's public responses, the Council served as a beacon of hope for HSA's, SHPDA's, and provider and consumer groups concerned about the development and impact of the original set of guidelines published September 23, 1978.

The Council is intended to provide a mechanism for coordinated deliberation about and response to the Department policies and proposals affecting the health care system. Its mandate crosses organizational lines within the Department since its composition is a microcosm of the forces that must work together to improve the health care system. The agenda materials prepared for the Council, as well as the minutes, have a wide circulation through direct distribution or through national newsletters. The Council has a symbolic role for the HSA's, SHPDA's, and SHCC's, as its broadly representative membership provides a means for input and output on national health policy that is not available elsewhere. The triple functions of the Council require liaison with other councils advising the Secretary, such as the PSRO Council and the National Health Insurance Council.

In recognition of its increasingly important role, the Department will allocate in 1978 three full-time positions to provide staff assistance to the Council and its chairman. The triple, interrelated functions of the Council cannot be performed by individual consultants. The key to the Council's effectiveness is the public discussion, the public consideration of widely different viewpoints, and the public resolution in the form of discussions on what to advise the Secretary on the development of national health policies. Each of the members represents constituencies which, as organizations or individuals, are not shy about pushing their special interests. The Council represents a forum in which the special interest concerns can be brought out in a focused discussion and the Department's responses can be enunciated.

Health Services Areas

To implement the law, the Congress authorized a network of areawide planning agencies, known as health systems agencies, which together will blanket the Nation. Each agency is responsible for a health service area of approximately 500,000 to 3 million residents. The designated area is intended to be a reflection of a health service or medical trade area with at least one center for the provision of highly specialized services. Wherever possible, standard metropolitan statistical areas (SMSA's) are to be contained in only one health service area, a provision which has resulted in 15 interstate HSA's. The areas were designated by the Governors of each State under Federal guidelines. The designation of health service areas was completed early in 1975, though some modification of a few areas is still being considered.

There are currently 213 health service areas. This is one more than initially designated in September 1975 and resulted from the division of a large sparsely populated area originally designated in Arizona into two areas. HSA and State boundaries are coterminous in 12 States (Delaware, Idaho, Maine, Mississippi, Montana, New Hampshire, Oklahoma, Puerto Rico, South Dakota, Vermont, West Virginia, and Wyoming); and another two areas are essentially so (New Mexico and Utah).

Under a special provision (sec. 1536), some States and territories were granted exemptions from the requirements to create a two-tiered (HSA and State) planning structure. They may combine the HSA and SHPDA functions in the latter agency, and all of the eight section 1536 States have chosen to do so. (Those eight so-called 1536 entities include American Samoa, District of Columbia, Guam, Hawaii, Rhode Island, Trust Territory of the Pacific Islands, the Virgin Islands, and the Northern Mariana Islands.)

Thus, with the eight section 1536 States, 22 of the 213 local health planning jurisdictions are statewide. Fifteen of the areas are interstate. One covering the Navajo reservation is tristate; the others are bistate.

Thirteen encompass interstate standard metropolitan statistical areas (SMA's). All but 36 of the over 270 SMSA's are included within a single area. Twenty-five of the 36 split SMSA's are interstate ones. The 36 split SMSA's were split either by waivers granted by the Secretary or by the granting of a section 1536 status (District of Columbia and Rhode Island). Six major metropolitan regions with split SMSA's contain approximately 23 million people or over 10 percent of the U.S. population. These regions are Boston, Chicago, San Francisco-Oakland, Washington, D.C., Memphis, and Philadelphia with the last three constituting major interstate SMSA's.

The population breakdown of these jurisdictions is as follows:

Under 500,000	54
500,000 to 999,999	89
1,000,000 to 1,999,999	49
2,000,000 to 2,999,999	16
3,000,000 and over	5

In terms of geographical size, health service area 3 in Alaska, which encompasses the northern two-thirds of the State with about 320,000 square miles, is the largest. The smallest is area 3 in New Jersey (Hudson County), covering only 46 square miles.

There is a reasonably high degree of congruity with Professional Standards Review Organization (PSRO) areas. There are 45 instances where health service areas and PSRO areas are identical. In another four instances (for example, Los Angeles, New York City), the health service areas completely encompass two or more PSRO areas. Conversely, 44 health service areas are wholly contained within single PSRO areas (for example, Colorado, Nevada). Of the remaining incongruent areas, half involve a difference of only one or two counties.

In only eight States (Alabama, Illinois, Kentucky, Nebraska, Pennsylvania, South Carolina, Virginia, and Wisconsin) did any of the areas officially designated by HEW differ from what their Governors had proposed.

As of April 7, 1978, six area redesignations have been formally requested since the initial establishment of health service areas in Sep-

tember 1975. Four have been approved and two are pending. One of those, however, the splitting of the single metropolitan Philadelphia area into three separate ones, was overturned by the Federal courts. Of the remaining requests, one from the State of Kentucky is currently undergoing formal regional and Bureau review and in the case of the other, from the State of Florida, the Secretary has granted the request but the action is under a temporary restraining order in the U.S. District Court.

Health systems agencies

There are now 205 health systems agencies designated under the terms of the act. They may be private nonprofit corporations (180), a public regional planning body if it meets special requirements (21), or a single unit of local government (4).

As of May 1, 1978, 71 HSA's had been granted full designation. Out of a total of 205 health systems agencies, 101 will complete their second year of conditional designation during the months of April and May, 1978. Most of these will be eligible for full designation. However, a few agencies not considered eligible for full designation will either be awarded waivers for a period of 1 to 12 months, or will be terminated. Receiving full designation satus indicates that an agency has been judged capable of carrying out all of the responsibilities required of it under Public Law 93–641. A major criterion in such a judgment is the adequacy of the health systems plan and annual implementation plan of the agency.

Agencies requesting a waiver, or extension of the conditional designation period, have to meet certain criteria, developed in accord with the committee's direction in its report on Public Law 95–215, providing an additional year of conditional designation for HSA's. The Health Planning Bureau has expanded and modified those circumstances specified in the committee report which will be taken into consideration in reviewing the agency's application for full designation or its request for a waiver.

These circumstances are regarded as minimum criteria. No agency can be considered for a waiver unless it substantiates that at least one of the criteria cited below has had a material effect on curtailing its developments:

Minimal funding of $175,000 or less in the first or second year that resulted in an inability to acquire sufficient staff to adequately assume all the functions required for full designation;

Designation of an HSA within a health service area that in whole or in large part had no previous local health planning agency and as a consequence required the HSA in its first 2 years to devote an excessive proportion of its activities and resources to organizational development, community involvement, basic needs assessments, resources inventories;

Litigation brought against the agency which prevented the orderly assumption of plan development or plan implementation activities, impeded organizational development (that is, a court ordered injunction requiring the agency to cease all activities for a specified period of time);

Related designation of the State health planning and development agency or statewide health coordinating council that resulted in the late issuance of a common plan format and other requirements; or where the SHPDA may have significantly revised the review criteria

or procedures to be followed by the health systems agency conducting capital expenditure or other required reviews; and

Resignation of the health service area that produced a significant change in the agency's governing body composition, budget, staff resources, community involvement activities, or plan development responsibilities.

These agencies must be governed by a governing board, a majority (51–60 percent) of the members of which are consumers, with the remainder of the Board representing physicians (particularly practicing ones), dentists, nurses, and other health professions, health care institutions, insurers, professional schools, and the allied health professions. The statute also requires representation of public officials, residents of nonmetropolitan subareas, and VA and HMO facilities, where appropriate.

A recent HEW study (September 1977) of 204 HSA governing boards revealed that consumers accounted for 53 percent (4,622) of the 8,707 members surveyed. Another 3,153 were classified as direct providers (physicians, nurses, health care institution administrators, dentists, health and allied health professionals). Women were generally underrepresented, forming only 26 percent of the consumer composition of boards. Consumer minority members filed 18.7 percent of governing board positions. Public officials made up almost 15 percent of the governing board composition, primarily categorized as consumer members (68 percent). Of the public officials on boards, 87 percent were local officials as compared to State and other officials (9 and 3 percent, respectively).

Of the provider category, 27 percent were physicians (including osteopaths), with dentists and nurses making 6 and 7 percent respectively of the governing board positions for providers. Representatives of health care institutions filled 37 percent of the provider slots on governing boards with health care insurers—six percent, health professional schools—7 percent, and allied health professionals—10 percent.

The survey indicated that HSA's encounter the most dominant problems with "representativeness" of the economic and social (age, sex) categories than with any other consumer category. Fourteen to sixteen percent of the agencies experienced problems in these areas, compared to 5 to 7 percent experiencing problems in other consumer categories.

With regard to problems of "representativeness" of the provider categories, the most frequent problems experienced were in the allied health professions and HMO categories. Seven percent of the agencies indicated they had experienced difficulty with "representativeness" of the public official category.

Eighty-eight HSA's have established 474 subarea councils (SAC's) with a total membership of approximately 15,460. The greatest number of the SAC's reflect a geographical base consistent with county boundaries, with State planning districts being the second most frequent base for SAC's.

In terms of size, the majority (113) of agencies had a governing body of 30 or fewer members. Sixty-six HSA's had between 31 and 70 members, with 24 HSA's having 70 or more members. Furthermore, 94 HSA's whose governing bodies numbered greater than 30 had established executive committees.

The 204 HSA's surveyed had staff totaling 3,212; 2,151 of these were professional staff and 1,061 were support staff. (There were also about 500 budgeted vacancies.) In addition to the eight HSA's which at the time of the survey were fully designated, 169 of the conditionally designated agencies had professional staffs that met the minimum requirement for full designation. With regard to the areas of expertise set forth in section 1512, the agencies indicated they were having the most problem recruiting staff with data and planning expertise.

The purposes of the planning agencies are to:

Improve the health of residents of a health service area;

Increase accessibility, acceptability, continuity and quality of health services provided;

Restrain increases in the cost of providing health services; and

Prevent unnecessary duplication of health resources.

The agency's primary responsibility is the provision of effective health planning for its area and the promotion of the development (within the area) of health services, manpower, and facilities which meet identified needs, reduce documented inefficiencies, and implement the health plans of the agency.

To meet these responsibilities, each agency must complete a health systems plan (HSP), which is a statement of long-range goals for the community. Not only are the plans themselves considered important documents for the public statement of the community's goals and objectives, but the plan serves as the basis on which all proposals for new institutional health services and programs, and applications for Federal funds under a significant number of Federal programs will be reviewed. In addition to the long-range plan, there must be an annual implementation plan which has specific objectives for each year or group of years within the minimum 5-year planning horizon of the HSP.

The agencies will also make recommendations to the State concerning projects for modernization, construction, and conversion of medical facilities, as well as review and make recommendations on proposals for new services and capital expenditures. Agencies will be reviewing existing services in terms of their appropriateness. In conducting these activities, agencies are required to coordinate with other federally sponsored initiatives (e.g., professional standards review organizations and the cooperative health statistics system), as well as existing planning activities under State and local agencies.

According to survey data validated December 1977, HSA's have been devoting one-fourth of their effort to plan development, as reflected by the functional budget breakdowns of the 143 agencies. A detailed breakdown of their allocation of funds indicates the following level of functional activity:

Function	*Funds (percent)*
Plan development	26
Agency organization and management	18
Plan implementation/review activities	16
Plan implementation/resource development	13
Data management and analysis	11
Public involvement and education	11
Coordination activities	5
Total	100

With regard to data, approximately three-fourths of the HSA's indicated they had adequate pertinent information on health resources; almost two-thirds had adequate data concerning health status and health care utilization. The two problem areas appeared to be environmental/occupational exposure factors and health financing and expenditures, with only one-third of the agencies indicating that they had adequate data in these fields.

The survey data indicated the following with respect to when the 197 conditionally designated HSA's expected to submit their HSP's and AIP's with applications requesting full designation:

By December 1977	58
By February 1978	57
By April 1978	43
By June 1978	23
By August 1978	8
After August 1978	6
Total	195

(Data not available for two agencies.)

In fiscal year 1976, the average planning grant for the 201 HSA's designated at the time was $315,191, or a per capita amount of $.37. In fiscal year 1977, the average grant per agency was $478,150, or $.46 per capita. It was estimated that the average per capita grant would reach $.49 in fiscal year 1978. A more detailed breakdown is shown below:

HEALTH SYSTEMS AGENCIES PLANNING GRANTS, FISCAL YEARS 1976–77

	Number of HSA's	Per capita	Average per agency
Fiscal year 1976:			
Less than minimum			
At $145,000	21	$0.65	$145,000
At $160,000	26	.37	160,000
At $175,000	24	.31	175,000
Over minimum	130	.29	399,603
Total	201	.37	315,191
Fiscal year 1977:			
Less than minimum	3	1.69	133,146
At minimum ($175,000)	23	.68	175,000
Over minimum	186	.46	519,655
Total	212	.46	478,150

FISCAL YEAR 1978 (ESTIMATE)

	Number of HSA's	Cost	Population	Per Capital
At minimum ($175,000)	28	$4,900,000	6,295,120	$0.78
Over minimum	185	101,030,000	210,029,827	.48
Total	213	105,930,000	216,324,947	.49

Note: Based on $8,000,000 local contribution.

The health planning statute and regulations issued on the designation and funding of HSA's require that HSA's seek to enter into

agreements with Professional Standards Review Organizations (among other entities with which the HSA's have a responsibility to establish cooperative arrangements). According to the American Association of Professional Standards Review Organizations, close to 100 of the potential 317 agreements, formally called memoranda of agreement, had been executed by February 23, 1978. Another 64 were in draft form, and 31 additional PSRO's reported that such agreements were under discussion.

One of the roadblocks to HSA/PSRO cooperation has concerned the issue of confidentiality of data requested of the PSRO. It was expected that once regulations were published by the Health Care Financing Administration (this occurred January 16, 1978) affecting the sharing of PSRO data and the issue of confidentiality, some of these conflicts would be resolved.

State Health Planning and Development Agencies

To assure coordinated State level planning, an agency of State government, chosen by the Governor, is designated to serve as the State health planning and development agency (State agency or SHPDA). The State agency must have an administrative program approved by HEW for carrying out its functions. All 56 State agencies have been designated. The organizational location of these agencies is as follows:

State health department	29
Health and welfare department	18
Governor's office	3
Independent agency or commission	3
With the remaining three in other agencies	

These 56 State agencies currently have staffs totaling 1,324; 900 of these are professional staff and 424 are support staff. (There are also an approximate 150 budgeted vacancies.) Staff size averages about 24.

The State agency is responsible for conducting the State's health planning activities and implementing the parts of the State health plan and plans of health systems agencies which relate to the government of the State. The agency will prepare a preliminary State plan from the health systems plans for approval or disapproval by the statewide health coordinating council (SHCC). The SHPDA also prepares and assists the council in the review of the State medical facilities plan (SMFP) and in the performance of its functions. It serves as the designated planning agency under section 1122 (capital expenditures review) of the Social Security Act, reviews new institutional health services proposed in the State, and the appropriateness of existing institutional health services.

SHPDA's are currently devoting 60 percent of their effort to performance of State agency functions as reflected by the following functional budget breakdowns submitted by 50 agencies:

Function	*Funds*
Administration of State administrative program	19
Performance State agency functions	60
Administration of SMFP	16
Administration of HSA functions/section 1536	5
Total	100

An earlier HEW study of 47 of the 56 SHPDA's revealed the following information regarding areas of expertise of their professional staff:

Category	*Percent*
Administration	19
Health planning	29
Resource development	23
SHCC	9
Other	18
Total	100

In terms of areas of expertise, the largest number of professional staff are in the health planning category. Conversely, the smallest number are reported as being principally concerned with support to the statewide health coordinating council (SHCC). (In the most recent study only 11 agencies indicated that they were providing staff support to the SHCC on a full-time basis.)

Directors' salaries range from a maximum of $45,000 to a minimum of $17,500. Professional staff salaries range from a maximum of $36,936 to a minimum of $6,700.

When examining data concerning working relationships between the HSA's and SHPDA's, the following areas were the major points of interaction (in descending order): HSP/AIP development; regulatory reviews; and development of standards and criteria.

The survey data indicates the following with respect to when the 56 conditionally designated SHPDA's expect to submit their State health plans with application requesting full designation:

By March 1978	10
By June 1978	28
By September 1978	9
Calendar year 1979	3
Total	50

(Information was not available for six agencies.)

As of April 1, 1978, only one State agency—that for Arkansas—had been approved for final designation.

In fiscal year 1977, statistics on SHPDA funding showed that the minimum Federal grant to 30 State agencies was $299,023. The average grant was $657,853, received by 22 agencies. Total Federal dollars from SHPDA funding reached $24.5 million in fiscal year 1977, with the total estimated Federal plus State dollars reaching a level of $39.1 million. Estimates for fiscal year 1978 for the 56 State agencies designated at that time show the minimum grant for 30 agencies to be around $365,000 with the average grant set at about $796,500, for a total Federal dollar contribution of $29.5 million. The combined Federal/State contribution for this activity in fiscal year 1978 is estimated to be $39.3 million.

The law also mandated the creation of statewide health coordinating councils where the interests and perspectives of the HSA's and the State come together. Sixty percent of SHCC members are appointed by the Governor from the State's health systems agencies, again with a requirement for a consumer majority. The council reviews annually and coordinates the health systems plans and annual implementation plans of the State's health systems agencies and makes

comments on them to the Secretary. The SHCC is responsible for a State health plan (SHP) comprised of the health systems plans. It also reviews budgets and applications of health systems agencies, advises the State agency on the performance of its functions, and reviews and approves or disapproves State plans and applications for formula grants to the State under a number of Federal health programs.

As of January 1, 1978, forty-one States have established statewide health coordinating councils. (Information regarding the District of Columbia SHCC, established in October 1977, was not available at the time of the survey). Their collective membership totals 1,425, with 53 percent representing consumers and 47 percent representing providers. There were 65 vacancies on these councils at the time of the survey.

Selected characteristics of these 41 agencies are as follows:

Authorized size	*Number of agencies*
Less than 25	4
25 to 30	11
31 to 40	15
41 to 70	9
Greater than 70	2
Total	41

Agencies with section 1512 provider categories represented

Physicians, dentists, nurses, et cetera	36
Health care institutions	36
Health care insurers	26
Health professional schools	30
Allied health professionals	30
Veterans' Administration	30

In an earlier HEW survey, 31 of the SHCC's submitted the following data concerning the characteristics of their members:

	Consumers		All	
	Number	Percent	Number	Percent
Sex:				
Female	246	40	358	30
Male	368	59	824	69
Minorities:				
American Indian	11	1.8	12	1.0
Asian/Pacific Islander	13	2.1	23	1.9
Black	81	13.0	125	10.5
Hispanic	22	3.5	27	2.3
Subtotal	127	20.4	187	15.7

	Number	Percent
Providers:		
Direct	434	77
Indirect	127	23
Physicians	112	27
Dentists	26	6
Nurses	21	5
Subtotal	159	39
Health care institutions	108	26
Health care insurers	33	8
Health professions schools	53	13
Allied health professions	55	13

Note: The 2d of the above breakdowns does not include the 130 provider members who were rea dily classifiable in terms the section 1512 categories. Nor does it include the VA and HMO representatives serving on these 31 SHCC's.

Public officials	November	Percent
Total	136	11.4
Consumer members	93	68.0
Provider members	43	32.0
Elected officials	85	62.0
Appointed officials	51	38.0
State	43	32.0
Local	66	48.0
Other	26	19.0

Mental health, drug abuse, and alcoholism interest representative

Number	93
Percent	7.8

Of the 15 SHCC's not included in the survey, 10 were established during the September—December 1977 period and the remaining four SHCC's were to be established in early calendar year 1978.

Under Public Law 93–641 all States must develop a certificate of need (CON) law which assures that only those services, facilities, and organizations which are found to be needed by the planning agencies are offered and developed in the State. While some States have had certificate-of-need laws since the late 1960's, this is the first time that all States have been required to institute such programs. The certificate-of-need process attempts to prevent the blatant duplication of services and facilities which exists in some locations—for example, hospitals within 5 minutes of each other offering identical high technology services with neither operating near capacity or even a minimum load for maintaining quality standards. Over the long run, CON attempts to create a more coordinated, regionalized system for health services.

The following table shows the status of certificate of need and section 1122 programs in the States (as of January 31, 1978):

State	Year certificate of need 1st enacted	Effective date of sec. 1122 agreement
Alabama	1977	Sept. 18, 1973
Alaska (effective 1977)	1976	Apr. 1, 1974
Arizona	1971	
Arkansas (fully designated SHPDA)	1975	July 1, 1973
California	1969	
Colorado	1973	Mar. 1, 1974
Connecticut	1969	
Delaware		July 1, 1973
Florida	1972	Jan. 1, 1973
Georgia	1974	Feb. 27, 1974
Hawaii	1974	(1)
Idaho		Feb. 1, 1974
Illinois	1974	
Indiana		July 1, 1973
Iowa	1977	Mar. 7, 1973
Kansas	1972	
Kentucky	1972	Mar. 15, 1974
Louisiana		May 16, 1973
Maine		Mar. 1, 1973
Maryland	1968	Feb. 15, 1974
Massachusetts	1971	
Michigan	1972	Dec. 14, 1973
Minnesota	1971	Feb. 25, 1974
Mississippi		June 25, 1973
Missouri		(2)
Montana	1975	Feb. 26, 1974
Nebraska		Feb. 26, 1973

See footnotes at end of table.

Nevada	1971	Mar. 15, 1974
New Hampshire		Apr. 1, 1973
New Jersey	1971	Feb. 28, 1974
New Mexico		July 1, 1973
New York	1964	Feb. 28, 1974
North Carolina		Apr. 2, 1973
North Dakota	1971	Feb. 28, 1974
Ohio	1975	June 28, 1974
Oklahoma	1971	Feb. 27, 1974
Oregon	1971	Mar. 1, 1974
Pennsylvania		Mar. 1, 1973
Rhode Island	1968	
South Carolina	1971	Mar. 15, 1974
South Dakota	1972	
Tennessee	1973	
Texas	1975	
Utah		Feb. 26, 1974
Vermont		Jan. 1, 1975
Virginia	1973	(2)
Washington	1971	Feb. 1, 1974
West Virginia	1977	Mar. 15, 1977
Wisconsin	1977	Sept. 1, 1973
Wyoming	1977	Feb. 28, 1974
District of Columbia	(3)	
American Samoa		
Guam		May 6, 1974
Northern Marianas (effective 1978)	1977	
Puerto Rico	1975	Feb. 28, 1974
Trust territory	1977	
Virgin Islands		
Total	(4)	(5)

[1] Terminated Feb. 28, 1977.
[2] Terminated June 30, 1976.
[3] By regulation, mid-1960's.
[4] 36 States; 3 territories plus the District of Columbia.
[5] 37 States; 2 territories; 3 States terminated.

The certificate-of-need laws vary with each State, consistent with Federal requirements, although all must include requirements for approval of any new construction or significant capital expenditure. The certificate-of-need provisions of Public Law 93–641 improve upon the capital expenditure review provision (section 1122) of Public Law 92–603, the 1972 amendment to the Social Security Act, which encouraged States to participate in capital expenditures review programs. In enacting the section 1122 program, Congress wanted to make certain that reimbursement for depreciation under Federal programs (medicare, medicaid, maternal and child health) was made in line with the then-designated planning agency's approvals. When all States have effective certificate-of-need programs which are generally more comprehensive than the section 1122 controls, there will be no further need for the 1122 capital expenditures review program.

The Department issued regulations specifying the minimum requirements for satisfactory State certificate-of-need programs on January 21, 1977. (There regulations were strengthened by amendments published in the Federal Register on April 8, 1977.) These Federal certificate-of-need regulations, in setting forth the minimum requirements for State certificate-of-need programs, drew upon the experience of the States and the Department in administering certificate-of-need and section 1122 programs, so that the weaknesses of these programs would be overcome.

The Department is requiring that State health planning and development agencies administer certificate-of-need programs which

meet the minimum Federal requirements in order to become fully designated and, thus, to participate fully in the programs authorized by titles XV and XVI of the Public Health Service Act. The HEW Regional Offices have the primary responsibility for providing assistance to the State in the development of satisfactory certificate-of-need programs, and they have been delegated the authority to approve or disapprove the certificate-of-need programs of each State.

Considerable effort has been expended in working with the States to develop certificate-of-need programs which comply with the Federal regulations.

The certificate-of-need review function required of State health planning and development agencies is intended to promote the more efficient allocation of scarce health resources. In every State and Territory, these agencies are gearing up for certificate-of-need review responsibilities. If this review responsibility is assumed in gradual fashion, with the proper foundation being laid in the way of review criteria, health plans, and Federal financial support, the Committee feels this review should yield significant results. If this review program is structured to keep abreast of changes in the health care system (for example, the presence of institutional health services in noninstitutional settings) and if it is properly integrated with other regulatory mechanisms, such as rate review, the result should be a more efficient allocation of health resources in the country.

Grants for rate review

Section 1526 of the act authorized a program of demonstration grants to be awarded to State agencies for purposes of rate regulation. Administration of this program was delegated to the health care financing administration, which also has responsibility for administering the research and experimentation grant program for ratesetting authorized under section 222 of the Social Security Amendments of 1972—Public Law 92-603. At the present time, no funds have been awarded under this authority since only States having a fully designated State agency are eligible (the State agency in Arkansas is the only SHPDA fully designated at this time). One obstacle to implementation of this section has been the Health Planning Act's provision that the rate review demonstration program be conducted by the same agency—the SHPDA—having responsibility for health planning functions. At the present time, State rate review or rate setting activities are often conducted by separate commissions independent of the SHPDA. According to Department spokesmen, the HEW Office of General Counsel has been considering proposals to allow rate review grants to be made if the SHPDA and the ratesetting authority in the State are structurally organized under the same umbrella authority. With this consideration in mind, seven to nine State programs have tentatively been identified as possible future section 1526 bases. The act authorizes grants for such purposes to a maximum of six State programs.

Centers for health planning

Ten regional centers for health planning have been funded to serve as back-up agencies for the local and State planning programs, as authorized under section 1534 of the act. These centers have produced a variety of products ranging from a guide to regulatory activities

under Public Law 93–641 to an educational manual for HSA volunteers to an evaluation of the implications of capital limitation programs in the health industry. Staff size has ranged from three professionals and one support staff in region X to nine professionals and three support staff in region VI.

Health resources development

The second major part of the act, title XVI, replaces the older medical facilities construction program—best known as Hill–Burton. The new program authorizes funds predominately for modernization of medical facilities, construction of new outpatient or ambulatory facilities, and conversion of existing medical facilities for the provision of new health services. Money for construction of new inpatient medical facilities is available only in areas which have experienced rapid recent population growth.

The implementation of title XVI is also tied systematically to the entire health planning program, which was not true in previous facilities oriented legislation. This not only has the advantage of enhancing the rational development of resources, but gives the planning side of the program some further financial and political significance. For example, the State agency must have a State medical facilities plan (SMFP) which is approved by the SHCC, and is consistent with the State health plan. While it is a separate document, the SMFP is considered to be a more specific facilities-oriented part of the State's plan for improved health. It is also the only plan to be established under Public Law 93–641 which requires the approval of the Secretary of HEW.

These features have meant that, until the planning structure is in place, most of title XVI cannot be implemented. The major exception is a project grant program authorized by section 1625 which provides some funds for the modernization of public medical facilities. As of January 1978, however, none of the currently available funds ($11,387,-200) have been obligated. As of December 23, 1977, $11,377,009 has been offered for commitment to four applicants (the first four on a ranking list) whose applications were found approvable. These four have been placed on a funding list. Obligation of these commitments is conditional upon the satisfactory completion of further actions (a normal feature of construction programs).

Proposed regulations pertaining to this section of the law were published November 26, 1976. Final regulations were published December 9, 1977. As of a January 25, 1977, deadline specified in the proposed regulations, 136 applications were received requesting approximately $137.2 million in grant funds. Total project costs were estimated at approximately $200.1 million. Individual application grant requests ranged from a low of $8,000 to a high of $7 million.

Currently, some $40 million remains available for title XVI of the Public Health Service Act. These funds were appropriated for "formula" construction and modernization grants to the States. For a number of reasons, it appears unlikely that such funds may be allotted to the States, committed, or obligated to needed projects before the appropriation authority expires (September 30, 1978). Consequently, action has been initiated toward seeking congresional approval to reprogram these funds and use them for the section 1625 program.

Title XVI also authorizes an appropriation for the HSA's to administer grants for planning and development activities identified in the health systems plan. The area health services development fund can be used to stimulate the development of services but not for actual delivery of services. This part of the program also cannot be implemented until planning is complete. As a whole, title XVI reflects Congress' intention to provide resources to encourage the implementation of the health systems plans.

Funding Levels

The following tables provide an appropriations history of health planning and predecessor and authorization and appropriations under Public Law 93–641:

APPROPRIATIONS HISTORY OF HEALTH PLANNING AND PREDECESSOR PROGRAMS

[In thousands of dollars]

	Fiscal year—									
	1970	1971	1972	1973	1974	1975	1976	1977	1978	1979
CHP	20,650	22,803	25,935	34,800	38,327	29,400	28,000	----------	----------	----------
Hill-Burton	186,123	196,521	308,204	203,578	210,554	----------	51,760	----------	----------	----------
RMP	100,000	116,990	102,854	134,625	81,953	50,000	10,000	----------	----------	----------
Health planning	NA	NA	NA	NA	NA	10,000	90,590	130,000	145,000	152,300
Total	306,773	336,314	436,993	373,003	330,834	89,400	180,350	130,000	[1] 145,000	152,300

[1] $2,000,000 transferred to HCFA for rate regulation program.

AUTHORIZATIONS/APPROPRIATIONS UNDER PUBLIC LAW 93–641

[In thousands of dollars]

	Authorization				Appropriation				1979 (request)
	1975	1976	1977	1978	1975	1976	1977	1978	
Health systems agencies	60,000	90,000	125,000	125,000	----------	64,090	97,000	107,000	115,400
State agencies	25,000	30,000	35,000	35,000	----------	19,000	24,500	29,500	30,000
Rate regulation	4,000	5,000	6,000	6,000	----------	----------	2,000	[1] 2,000	----------
Centers for health planning	5,000	8,000	10,000	10,000	10,000	7,500	6,500	6,500	6,900
Area health services development	25,000	75,000	120,000	120,000	----------	----------	----------	----------	----------
Health facilities construction:									
Sec. 1602 formula grants	125,000	130,000	135,000	135,000	----------	[2] 51,760	----------	----------	----------
Sec. 1625 project grants	----------	----------	----------	67,500	----------	----------	----------	----------	----------
Total	244,000	338,000	431,000	498,500	10,000	142,350	130,000	145,000	152,300

[1] Program budget transferred to HCFA.
[2] 22 percent of this may be used for sec. 1625 project grants.

V. History of S. 2410

The legislation was introduced on January 23, 1978, by Senators Kennedy, Schweiker, Javits, Randolph, Pell, and Chafee and was referred to the Committee on Human Resources. On February 2, 3, and 6, 1978, the Subcommittee on Health and Scientific Research held a series of hearings on this legislation, "The Health Planning Amendments of 1978."

Testimony was received from the Department of Health, Education, and Welfare. There was general agreement among the many witnesses that there is a need for this planning legislation, although not all supported the legislation in its entirety.

February 2, 1978:

Witnesses included:

Hon. J. Joseph Garrahy, Governor, State of Rhode Island, chairman of the National Governor's Association, Subcommittee on Health Policy.

Hon. Edward Herschler, Governor, State of Wyoming.

Hon. Hale Champion, Under Secretary, Department of Health, Education and Welfare, Washington, D.C.

Consumer Coalition for Health Panel:

Mr. Herb Semmel, director, Consumer Coalition for Health, Washington, D.C.

Mr. Steve Suittes, Southern Regional Council, Atlanta, Ga.

Mr. Willie Mitchell, National Health Law Program, Newman, Ga.

February 3, 1978:

Witnesses included:

Hon. Terrence L. Pitts, supervisor, Milwaukee County, Wis., National Association of Countries.

Representative Joseph Czerwinski, chairman, Committee on Health and Social Services, Wisconsin State Assembly, Milwaukee, Wis., National Confernce of State Legislators.

A Panel of health Care providers:

Mr. John Alexander McMahon, president, American Hospital Association.

Frank P. Jirka, M.D., vice chairman, American Medical Association, Board of Trustees.

Mr. Michael Bromberg, director, Federation of American Hospitals.

A panel of health systems agencies representatives:

Mr. Anthony Mott, executive director, Finger Lakes H.S.A., Rochester, N.Y.

Mr. James Suter, executive director, West Virginia H.S.A., Inc., Charleston, W. Va.

Ms. Dorothy Hoskins, chairman of the governing body, Western Colorado H.S.A. Grand Junction, Colo.

A panel representing the Washington Business Group on Health:

Mr. Richard Martin, manager of Health Services Relations, Goodyear Tire and Rubber Co., Akron, Ohio

Mr. John L. Brown, Genesco, Inc., director of employee benefits, Nashville, Tenn.

February 6, 1978:

Witnesses included:

Mr. Dick Clark, U.S. Senator, State of Iowa

Mr. Patrick Leahy, U.S. Senator, State of Vermont

Mr. Bert Seidman, director, department of social security, AFL–CIO, Washington D.C.

Mr. Stanley Wisniewski, research director. Service Employees International Union, Washington D.C.

Mr. Robert McGarrah, American Federation of State, County and Municipal Employees, AFL–CIO, Washington, D.C.

Mr. Melvin Glasser, director, social security department, United Auto Workers, Detroit, Mich.

Panel of insurance industry representatives:
Mr. Neil Hollander, vice president of health care services, Blue Cross Association, Chicago, Ill.
Mr. Henry A. DiPrete, second vice president, group operations, John Hancock Mutual Life Insurance Co., Boston, Mass.
Panel of medical equipment manufacturers:
Dr. Walt Robb, vice president and general manager, medical systems division, General Electric Co., Milwaukee, Wis.
Mr. Michael Grimm, president, Technicare Corp., Solom, Ohio

In addition, statements were supplied for the record by the following organizations and individuals:

American Academy of Pediatrics.
American Association of Hospital Consultants.
American Association of Neurological Surgeons and the Congress of Neurological Surgeons (Louis A. Finney, M.D.).
American Dental Association.
American Nurses Association.
American Osteopathic Association.
American Osteopathic Hospital Association.
American Psychiatric Association.
American Public Health Association.
Appalachian Georgia H.S.A., Inc.
Association of American Medical Colleges.
Association of Rehabilitation Facilities.
The Bennet Group/Health Services.
California Medical Association.
Caughman, Ken.
City of Philadelphia.
Gila River Indian Community.
Family Health Program.
Group Health Association (Louis Segadela).
H.S.A. of Southwestern Pennsylvania.
Hopi Indian Tribe. Testimony of Abbott Sekaquaptewa.
Idaho, State of.
Keene, Hon. Barry.
Kilpatrick, Rogers, McClatchey & Regenstein (law offces).
Maine Hospital Association.
Massachusetts Association of Community Health Agencies.
National Association of Regional Councils.
National Association of Retired Persons & National Retired Teachers Association.
National Association of Single State Agencies.
National Association of State Mental Health Program Directors.
National Council of Community Hospitals.
National Council of Community Mental Health Centers.
National Electrical Manufacturers.
National Farmers Union.
North Central Georgia HSA, Inc.
North Puget Sound Health Council.
Nunn, Hon. Sam.
Public Citizens Health Research Group.
Renal Physicians Association.
St. Francis Hospital.

Schneier, Max.
Southwest Georgia HSA, Inc.
Teledyne Brown Engineering.
Texas Area 5 HSA, Inc., Dr. Louis Gibson.
Texas Hospital Association.
Texas Statewide Health Coordinating Council.
Texas, University of, Health Science Center.
West Central Illinois HSA, Inc.
Western North Dakota HSA.

The legislation was subsequently considered in open executive session by the Subcommittee on Health and Scientific Research on April 7, 1978, at which time the bill was amended and ordered favorably reported to the Committee on Human Resources. This bill was considered in open executive session on May 4, 1978, by the Committee on Human Resources, amended further, and as further amended, ordered favorably reported to the Senate.

VI. Committee Views

The major purpose of this legislation is to strengthen and build upon the already functioning health planning network. The committee in its deliberations has strongly emphasized that health planning should be a process in which both consumers and providers of health and mental health services work together to effectuate a better and more rational health delivery system than exists today.

The committee has found that the need for strengthened and coordinated planning for personal health services grow more apparent each day. In the view of the committee the health care industry does not respond to classic marketplace forces. The highly technical nature of medical services, together with the growth of third party reimbursement mechanisms, acts to attenuate the usual forces influencing the behavior of consumers with respect to personal health services. For the most part, the doctor makes purchasing decisions on behalf of the patient and the services are frequently reimbursed under health insurance programs, thus reducing the patient's immediate incentive to contain expenditures.

Investment in costly health care resources, such as hospital beds, coronary care units or radiation treatment centers is too often made already operating in the same or a nearby area. Such investment not only results in capital accumulation but also establishes an ongoing demand for payment to support those services. There is convincing evidence from many sources that overbuilding of facilities has occurred in many areas, and that maldistribution of high cost services persists.

A recently published study indicates that there are at least 100,000 unneeded hospital beds throughout the United States.

Hospital beds, though unused, contribute substantial additional costs to the health care industry. It is estimated that a hospital bed, full or empty, costs between one-third and one-half its initial purchase cost each year to operate. Each $1,000 invested in hospital expansion requires at least $333 each year in operational financing. This operating cost exists whether or not the bed is occupied at a particular time. The same is true with respect to other medical facilities and services. A

coronary care unit with a low rate of utilization, or an open heart surgery team which performs relatively few operations a year requires a substantial proportion of the support required by similar services with a high utilization rate.

Widespread access and distribution problems exist with respect to medical facilities and services. In many urban areas, hospitals, clinics, and other medical care institutions and services are crowded into relatively tiny sectors, while other large areas go poorly served or completely unserved. Many rural communities are completely without a physician or any other type of health care service, while adjacent urban areas are oversupplied.

Section 101(a) of the committee's bill amends section 1503(b)(1) expanding the membership of the National Health Planning Council from 15 to 18 members in order to assure that the council includes individuals who are members of urban and rural medically underserved populations and the Assistant Secretary for Rural Development of the Department of Agriculture. The committee believes that special attention should be paid to the needs of medically underserved areas. The committee feels that the Assistant Secretary for Rural Development of the Department of Agriculture will bring a unique perspective on the needs of rural populations.

Section 101(c) of the committee bill amends section 1501(b)(1) to assure that the national guidelines for health planning include standards that reflect the unique circumstances and needs of medically underserved populations including isolated rural communities.

Until recently, no nationally applicable guidelines for health policy have existed. In view of the increasing Federal involvement in and responsibility for the provision and assurance of health care services to the American people, the committee believes that it is appropriate for the Secretary, with the advice of the National Council on Health Planning and Development, to promulgate health planning guidelines. Although the committee wishes to reemphasize ultimate congressional authority and responsibility for developing the basic framework for Federal health policy through legislative activity, it believes that the executive branch has a clear responsibility to promulgate guidelines with respect to the appropriate supply, distribution, and organization of health resources, and with respect to national health planning goals, taking into consideration national health priorities described in the proposed legislation. The committee believes that the major responsibility for the implementation of health planning lies with local and State planning agencies. The committee believes that the promulgation of guidelines should be a continuing process that should keep pace with changes in data and technology.

It is intended that areawide and State health planning bodies use the guidelines developed by the office of the Secretary of HEW in formulating their plans required by the proposed legislation.

Section 101(b) and section 102 of the committee's bill amend section 1511(b)(4) concerning the designation of the boundaries of health service areas. It is the committee's intent that the Secretary retain the final authority in the redesignation process and that redesignation should take place only if there is evidence that the boundaries of the health service area no longer meet the requirement of section 1511(b)(4)(a) or if the boundaries for a proposed revised

health service area meet the requirements of the same subsection (a) in a significantly more appropriate manner in terms of the efficiency and effectiveness of health planning efforts. If the Secretary acts on his own initiative to revise the boundaries of any health service area he shall consult with the Governor of the appropriate State or States concerned, the chief executive officer or agency of the political subdivisions within the State or States that would be affected by the revision, the appropriate designated health systems agency or agencies, and the appropriate established statewide health coordinating council or councils. The committee in its bill, has required that for each proposed revision of the boundaries of a health service area, the Secretary shall give notice and an opportunity for a hearing on the record by all interested persons and shall make a written determination of its findings and decisions.

The committee believes that under current law redesignation requires a finding that an area is no longer appropriate. This has proven troublesome and unnecessarily restrictive. The committee believes that some restrictions are necessary since redesignations are not to be encouraged. The proposed change would permit more flexibility to respond to changes that may influence the effectiveness of planning.

Sections 104(a) and (b) of the committee's bill amend section 1512(b) and section 1524(b), respectively, to add new subsections expanding and clarifying conflict of interest provisions for HSA and SHCC members. This proposed amendment directs HSAs and SHCCs to adopt procedures (in accordance with regulations of the Secretary) to assure that no member, employee, consultant or agent participate in any matter regarding any persons, institutions, organizations, or other entity with which such individual has or has had within the past 3 years any substantial direct or indirect employment, fiduciary, competitive, medical staff, ownership, or other financial interest. This amendment is also intended to avoid any potential conflict of interest arising from the redefinition of "indirect provider" described in section 140 of the committee's bill. The committee, in its development of the bill, believes that this provision is exceedingly important. The committee intends "competitive interest" to mean that an individual has an affiliation or other relationship with an institution, organization, or other entity which is in competition with an institution, organization, or other entity, and when this "competitive interest" exists that the individual not participate in certificate of need decisions and other decisions of similar nature. The committee does not intend that this provision should be construed so broadly as to entirely prevent provider members of HSAs and SHCCs from voting on any matter relating to health care institutions and other providers such as may take place in the development of the health systems plans, annual implementation plans, and State health plans. Such an interpretation, the committee believes, would broaden the scope in such a manner that the planning process could become exceedingly cumbersome.

The medical staff relationship is particularly important. A physician on an HSA board speaks with all of the imputed authority of a physician. He should not be able to speak on whether or not the hospital in which he practices should obtain a particular piece of equipment.

Moreover, the committee believes that he should not participate in the review of an application of another competing hospital. Just as he has an interest in what equipment his hospital obtains, he also has an interest in what equipment a hospital at which he does not practice obtains since it could affect his practice and his hospital. Thus the committee instructs the Secretary, in developing regulation for this section to provide that anyone on the medical staff of a hospital that has a competitive relationship with another hospital be included within the scope of the conflict of interest provisions.

Testimony by consumers, business, labor, providers, and health planning organizations indicated that the conflict of interest provisions should be applied to prevent competitive interests from thwarting the growth and development of health maintenance organizations. As an alternative comprehensive delivery system, approval of HMO applications cannot be determined by standards for what is already available in the community. Therefore, these criteria are set forth in the proposed law.

Section 105(a) of the committee's bill amends section 1515(b)(2)(A) to add additional requirements for HSA staff to assure expertise in financial and economic analysis, public health and disease prevention, and mental health planning. Research has indicated that many HSAs are focusing almost exclusively on medical care. Health is also a function of nutrition, lifestyle, environmental factors, et cetera. In order to improve health and reduce costs, the committee believes that the HSAs should take a broader perspective on all aspects of health and the relation between health and medical care. Similarly, if HSAs are to be successful in their newly expanded hospital cost control mission, they must be aided by staff who can provide sound economic analysis of the health system and the probable financial impact on the community of various HSA decisions.

Section 105(c) of the committee's bill amends section 1512(b)(2)(A) by requiring that at least one member of the HSA staff be assigned responsibility for providing the consumer members of the governing body with such assistance as they may require to perform their functions effectively.

The committee believes that consumers can make valuable contributions to functions of the HSA because of their awareness of community needs and community interests. Yet their meaningful participation may be hampered by unfamiliarity with technical jargon or inability to analyze complex financial data. This exacerbates provider domination in such important functions as certificate of need review. This problem was described in testimony.

In addition, the committee found that many HSAs have been seriously deficient in attempts to encourage consumer involvement. By assuring that every HSA will have at least one staff person with this goal as his/her sole concern, meaningful consumer participation can be realized in all plan functions.

The committee intends that the responsibilities of this staff member should include: (1) education of consumer members with regard to health care and health planning; (2) encouragement and facilitation of involvement of consumers in HSA functions; (3) provision of technical assistance to consumer members; (4) attendance at and

monitoring of board, subcommittee and advisory group meetings; (5) review of proposed health systems plans, annual implementation plans, grants, contracts, project reviews, and certificate of need applications; (6) facilitation and review of solicitation, slotting and election of board members; and (7) evaluation of the effectiveness of the health systems agency in achieving its stated goals.

Section 106 of the committee's bill amends section 1512(b)(3) to add a new subparagraph setting forth the broad outlines for the selection process to be used by the HSA in selecting members of its governing body and subarea councils. The amendment provides that broad participation by residents of the health service area which is to be encouraged and facilitated, and HSA members are not to select other members of the HSA. The selection process is to be made public and reported to the Secretary. This proposed amendment addresses the concern of many observers of the planning program that HSAs have not to date pursued a consistent and aggressive policy to include members reflecting the full range of consumer, provider, and public interests in the community.

The committee was particularly concerned by testimony concerning the process through which consumer and provider representatives are appointed to HSA governing bodies. The present law allows an HSA governing body to be self-appointed. The committee is concerned that as a result of current law, these agencies, which are supposed to be open and accessible, can become closed with a handpicked board providing policy direction, unsupported by the general public.

The committee viewed such a prospect with alarm. The provision that the governing bodies be broadly representative was intended to assure that major interests, both consumer and provider, would have a meaningful voice in the formulation of HSA policies and decisions.

Some HSAs, because of the complex representational requirements and because of the desire to appoint people whom they feel represent a constituency's best interest, have, in effect, circumvented the intent of Congress in creating the governing body structure.

To assure that the HSA governing bodies contain representatives of groups or constituencies which are not appointed by the HSA itself, the committee has included a provision prohibiting the HSA governing body or a committee composed of governing body members from appointing new members to the governing body. This provision mandates the HSAs to go to the various interests or constituencies in the community for appointments. It is also intended to reduce the incidence of appointment to the HSA governing body of individuals who are members of groups or constituencies but have no claim to speak for the interests of such group. It is the intent of the committee that an individual purporting to represent a social or economic group, linguistic or racial population, geographic areas, major purchaser of health care, or the various provider interests must show a constituency relationship with such group. Being a member of a group is significant but in itself not sufficient to prove representativeness. Rather, the individual must show that he/she is able to speak for the interests of the constituency through a formal delegation of authority or because of a documented knowledge of the health and medical care problems of the group.

HSAs must encourage public participation in order for issues of equity to be considered and board decisions to be creditable and acceptable to the general public. By providing more concrete direction as to the selection of board members, it is hoped that the intent of the law will be more effectively realized. This amendment was also intended to deal with certain cases where HSA boards have apparently been self-initiated and self-perpetuating as indicated the committee believes that current HSA members not be allowed to select new participants. There have been reports of self-perpetuating HSA boards where new representatives are selected by combined vote of consumer and provider representatives. This has, in some instances, resulted in provider domination of the selection of consumer representatives. Because of the diversity of organization of HSAs, the committee feels that it is not feasible to prescribe a particular method of selection for every HSA. The provisions of the proposed amendment will allow for greater accountability to the public at large as well as to constituency, the particular organization or group that an individual may represent.

The committee received considerable evidence, including a report prepared for HEW, which indicated that the broadly representative requirement for the consumer members of HSA governing bodies is not being met. Lack of compliance appears serious particularly with regard to low and moderate income persons who are often substantially underrepresentated in comparison to the percentage of the population which these economic categories comprise. The committee believes that the problem is primarily one of lack of enforcement of the statutory requirements. In view of the commitments by HEW, expressed at the hearings, to issue regulations in the immediate future which will strictly enforce the broadly representative requirement, no change in the statute was deemed necessary by the committee at this time. The committee intends to watch closely the actions of the Department in this important area.

Section 107 of the committee's bill amends section 1512(b)(3)(A) to provide that an HSA that is a public regional planning body not be required to delegate to a separate governing body for health planning the exclusive authority to appoint and with cause remove members of the governing body for health planning; establish personnel rules and practices for the staff of the governing body for health planning; or approve the agency's budget.

In writing Public Law 93–641, Congress established two model legal structures for HSAs. One was the private, nonprofit corporation and the other was the public body—either a city, county, public regional planning body or a joint powers agency. Presently, there are 180 private HSAs and 24 public agencies.

The respective roles and relationship of the regular governing board and the separate governing body for health planning of a public HSA have proved to be a source of continuing controversy. This revision would expand the degree of control that may be exercised by a public HSA's regular governing board over its separate governing body for health planning.

Since the passage of the Act in 1974, there has been considerable confusion over the powers of a public HSA governing board—the city council, county board of commissioners or supervisors, the regional

planning board or the joint powers board. The Secretary, in developing guidelines for this provision, indicated his concern that giving the governing body only the power to appoint the governing body for health planning would "engender disabling conflicts" between the two bodies (41 F.R. 12812 (1976)). In a subsequent letter, dated September 9, 1976, the Secretary noted:

> The respective roles and relationship of the separate governing body for health planning and its parent public regional planning body or unit of general local government have proved to be a controversial feature of the National Health Planning and Development title of the Public Health Service Act. There is a significant inconsistency between the statutory language and what a number of Congressmen assumed from brief colloquies would be the relationship between the separate governing body and its parent body.

Finally, in the case of *Maryland* vs. *Califano* (Civil No. K 77–166 mimeo), Judge Kaufman noted that the Secretary's limitation of the powers of the governing board to that of the appointment of the governing body was not supported by the statute.

The committee has reviewed the relative powers of the governing body and the governing board of the public HSA with care. The committee believes that if a public HSA is to be permitted under the statute, and we believe that it should, then the governing board should have significantly increased authorities to establish overall plans and policies. Therefore, the committee has amended section 1512(b)(3)(A) as indicated above.

Section 107(b) of the committee's bill amends section 1512(b)(3)(C)(iii)(I) clarifying the definition of "representatives of governmental authorities", by requiring that for an individual to be considered a representative of a unit of general purpose government, an individual must be appointed by such unit or a combination thereof.

The committee received testimony from National Association of Counties and other groups representing general purpose local government concerning the ambiguity in the definition of "public elected officials and other representatives of governmental authorities" as used in section 1512(b)(3)(C)(iii)(I). The present statutory language allows coroners, treasurers, deans of medical schools, faculty of community college health science programs, and public health nurses all to be appointed without the knowledge or consent of the local government. Yet there is the inference, if not claim, that these individuals "represent the interests of the city or county or the HSA governing body."

The committee was also concerned that in some HSAs there seems to be an attempt to exclude local officials. These activities have further aggravated the problems of encouraging the participation of local elected officials.

The committee believes that the HSAs must continue to seek the meaningful involvement of all segments of the community, including local government and its elected leadership. To encourage this, the committee has added a provision to assure that "public representatives or other representatives of general purpose government" are appointed to HSA governing bodies. The committee further amended

the statute to require that these representatives be appointed by units of government or combinations of units of government.

The committee avoided setting national quotas for the level of involvement of elected officials on health systems agencies. However, we believe that these officials play an important role in building local community support for HSA policies, and the committee will closely monitor the implementation of the program to assure that each HSA maintains an appropriate level of involvement of local elected officials.

Section 108 of the committee's bill amends section 1512(b)(3)(B)(vi) to allow HSAs when appropriate to make advances to HSA members for their reasonable costs incurred in attending meetings and performing any other duties and functions of the health systems agency.

The committee received testimony indicating that many low-income consumers are unable to pay for the costs of participation in HSA activities despite the promise of ultimate reimbursement by the HSA. Because many of the important functions of the HSAs are performed not by the governing body but by other communities, the committee extended the reimbursement provision to these activities. The committee intends that reimbursable expenses include expenses such as travel, meals, and child care, and does not expect abuses in this area.

The committee recognizes that many HSAs, in conducting their business and writing their health systems plans, have relied upon thousands of hours of volunteer efforts by members of the governing body and others, outside of regular meetings of the governing body. The committee does not intend that genuine volunteer efforts should result in increased costs to the HSA as a result of this provision. Indeed, if governing body members were to claim expenses associated with all such volunteer efforts, many HSAs would go bankrupt overnight. Rather, it is the purpose of this provision to assure that all necessary duties and functions of the HSA receive sufficient attention from all board members, including consumer members to whom the performance of such duties and functions might be a financial hardship in the absence of such a provision.

As indicated the committee has approached the issue of the composition of planning agency governing bodies with the intention of avoiding changes in law which could disrupt or delay the development of local and state planning programs. Therefore, the committee has not included amendments that would require that the SHCC or the HSA governing bodies to include representatives of particular interests. Nonetheless, the committee reiterates the intention of Public Law 93–641 that planning entities seek the active involvement of providers in the health planning process, particularly in the governance of HSAs and SHCCs. In this regard, the committee notes testimony received by the Subcommittee on Health and Scientific Research indicating that not all HSAs have included representatives of hospital administration on governing bodies or executive committees in view of the priority of attention by such entities to the services and facilities of institutional providers.

Section 109 of the committee's bill amends section 1512(b)(3)(B)(viii), section 1512(6)(A), section 1522(b)(6) and section 1532(b)(10) to exclude from the open meeting requirement confidential HSA meetings on personnel issues which if public would constitute a

clearly unwarranted invasion of the personal privacy of such individual. The committee believes this to be consistent with Federal policy in other areas.

Section 110 of the committee's bill amends section 1512(b)(3)(C)(i) to remove the "12 month waiting period" in the definition of consumers for purposes of HSA board membership. Presently, anyone who has been a provider within the preceding 12 months may not serve as a consumer member of an HSA-governing body. This requirement has had the effect of precluding a person who serves or has recently served as a bona fide consumer member of the board of a health provider institution or organization (e.g., hospital boards of trustees, community health center advisory councils) from service on HSA boards for at least 1 year, even if he or she is willing to step down from his/her present position which makes him/her an indirect provider under current definition. Frequently, these are the consumers who by virtue of their experience, interest, and motivation would be among the most effective consumer participants on HSA boards, and for this reason the provision was added to the committee's bill. The committee intends that the conflict of interest provisions in section 104 of the committee's bill will assure that no trustee of a health care facility participate in decisions where a conflict of interest exists.

Section 111(a) of the committee's bill amends section 1512(b)(3)(C)(ii) to expand residency requirement as it pertains to providers of health care to allow HSA participation by providers who do not necessarily reside in but have their principle place of business within the respective health service area. While the majority of health providers reside in the health service area where they work, there are circumstances where this situation does not exist, e.g., in metropolitan areas where a provider lives in an area adjacent to the health service area. It is assumed that HSAs will, to the extent possible, seat members to their governing body from its health service area. The purpose of this amendment is to allow maximum flexibility to the HSAs to determine appropriate representation from provider as well as consumer interests.

Sections 112(a) and 112(b) of the committee's bill amend section 1512(b)(C)(ii) and section 1531(B)(A), respectively, to clarify that the term physician includes both doctors of medicine and osteopathy. This amendment will assure that the health planning program is consistent with other Government programs such as medicare in treating osteopaths on an equal basis with medical doctors.

Section 113 of the committee's bill amends section 1512(b)(3)(C)(ii) to broaden the provider of health care definition pertaining to HSA governing body composition. This adds additional provider categories for "nonprofessional health workers" and "other providers of health and mental health care". This is a clarifying amendment to permit providers who do not represent or fall into one of the current five enumerated categories to serve on HSA governing bodies.

Section 114(a) of the committee's bill amends section 1512(b)(3)(C)(iii)(II) to provide flexibility (but not mandate) for increased nonmetropolitan representation on HSA boards. The proposed amendment is designed to assure that the percentage of representatives from nonmetropolitan areas is "at least" equal to the percentage of residents in such nonmetropolitan areas. In the final deliberations on Public

Law 93–641, concern that rural areas would be underrepresented on HSA governing boards resulted in the current language providing for representation "equal to" the percentage of nonmetropolitan residents. However, rather than acting as a floor for participation by rural interests, this provision has placed a cap on their involvement. The goal of this amendment is to maximize flexibility and assure that these issues are resolved within the health service area.

Section 114(b) of the committee's bill amends section 1512(b)(3)(C)(iii)(III) to clarify that "ex officio" means nonvoting.

Section 115 of the committee's bill amends section 1512(b)(3)(C)(IV) to mandate that subcommittees of HSA boards have a consumer majority. Current law stipulates that subcommittees and advisory groups must meet such composition requirements "to the extent possible". Although it may be difficult for all committees to meet all representational requirements, because of small size, there is no reason not to require consumer majorities. In practice, committee reports (such as committees that review certificate of need applications) often become decisions of the larger bodies. The current loophole has in some cases resulted in provider-dominated committees. It has been reported that, in one area, the subarea councils (which must conform to HSA composition requirements) were reconstituted as area advisory committees because they lacked consumer majorities and were thus out of compliance with requirements for SAC's. The intent of the law was thereby subverted.

While this amendment would also apply the consumer majority requirement to advisory groups, as well as subcommittees, appointed by the HSA governing body, the committee should emphasize that such an amendment should not be construed to prohibit governing bodies from seeking advice from non-HSA advisory groups, such as medical or scientific technical panels or specialty groups. Such panels or groups are clearly not expected to change their composition in order to be permitted to give advice or technical assistance to the HSA. However, it should be emphasized that no such panel or group should be delegated decisionmaking authority by an HSA governing body. Moreover, it is intended that all advisory groups formed by, or specifically for the purpose of advising, an HSA contain consumer majorities, whether or not composed in whole or in part of HSA governing body members, and whether or not the purpose of the group is to give advice on technical scientific or medical matters.

Section 116(a) and section 116(b) of the committee's bill amend section 1512(b)(4) and section 1524, respectively to broaden the scope of protection against personal liability suits for HSA and SHCC staffs and members while in the scope of their official duties. The Committee heard testimony that failure to provide such protection could discourage the active citizen participation necessary for the success of the program. Existing language is not sufficiently protective as it requires the person to have exercised "due care" (which can be construed as meaning acting without negligence), and to have acted "within the scope" of official duties. Something that appeared nonnegligent and/or within the scope of official duties at the time the act was committed could be determined retrospectively by a judge or jury to be either negligent or outside the official scope of a person's duties, or both. Greater protection is provided in the committee's bill in that a more limited retrospective test is now applied.

The areawide health planning agencies were given prime responsibility by Public Law 93–641 for the development of a quantitative and specific health plan for the areas they serve. These plans were intended to form the foundation upon which the entire health planning process would be built. Each health planning agency was given substantial responsibilities for the accumulation of data in order to assess the existing status of the health care delivery system in the area it would serve and for developing short and long-term recommendations in order to achieve the rational and equitable distribution of personal health care services throughout its planning area. In identifying the health care needs of its area, each health planning agency was to consider environmental and occupational exposure factors affecting immediate and long-term health conditions.

The committee intended that health maintenance organizations, as well as other innovative organizations for health care delivery, would have adequate representation on the governing body of any health planning agency serving an area in which such innovative health care entities were operating. In view of the long history of resistance to any form of health care delivery not consistent with traditional concepts of medical practice, and in view of the obvious and well-documented need for reorganization and innovation in the health care field, the committee was, and still is, deeply concerned about the potential of health planning agencies to stifle rather than foster innovation in the health care delivery system. For that reason, the committee included an emphasis upon innovative health care delivery systems in requirements for national guidelines, and for State and areawide plans, and urged that adequate representation be given to representatives of such innovative entities on the policymaking boards of planning agencies.

In order to carry out its responsibilities, the health planning agencies were directed to assemble and analyze data describing the status of the health of the residents of the health area; to assess the number, type and location of the area's health resources, including health care personnel, facilities and programs; the patterns of utilization of those resources; to the extent possible, the effect of the health delivery system on the health of the residents of the area; and the environmental and occupational factors affecting the immediate and long-term health of the area's residents.

The health planning agencies were directed to establish long-range goal plans which could be anticipated to achieve a healthful environment in the area served. The long-range goal plan was expected to provide for the prevention of unnecessary duplication of resources and assure that quality health services would be available and accessible in a manner assuring continuity of care at reasonable costs for all residents of the area and in a manner responsive to the needs and resources of the area.

The agencies were directed to establish a short-term priorities plan, which was intended to be a tactical document to achieve the strategy outlined in the long-range goal plan. The long-range goal plan and the short-term priorities plan were intended to be, in the view of the committee, quantitative documents to the extent possible, outlining the projected requirements for health care facilities and services, for the health area involved. These documents were to be reviewed and updated on a continuing basis and, at a minimum, annually.

In developing their short- and long-term plans, health planning agencies are directed by the proposed legislation to give special consideration to those health care resources within their health planning areas which serve a community extending beyond a particular health planning area jurisdiction. For example, the Mayo Clinic in Rochester, Minn., the M. D. Anderson Medical Center in Houston, Tex., some of the medical facilities and programs in the Boston, New York, and Philadelphia areas, and many other centers of medical excellence throughout the country draw patients from all parts of the country and many parts of the world. In assessing the desirability of the need for expansion or modification of such facilities or services, it is the committee's intent that recognition be given to their role as regional or national resources, and that consideration not be limited to the role such health care resources play in a particular health area.

The committee believes that it is imperative that the health planning agency should be adequately funded in order to enable it to carry out its mandate. One of the problems resulting in the relative lack of effectiveness of existing health planning agencies is considered by the committee to be inadequate funding. It is hoped that the authorizations contained in the proposed committee legislation will prove adequate to support the extensive and complex activities of the health planning agencies.

Section 118(a) of the committee's bill amends section 1513(b)(2) to increase the material to be included in the HSP in conformity with the increased scope of the State health plan. In addition to other requirements, the HSP must include a description of institutional health services needed for the well-being of persons receiving care within the health service area, including at a minimum, the number and type of medical facilities, rehabilitation facilities, nursing homes, beds, and equipment needed to provide acute inpatient, psychiatric inpatient, obstetrical inpatient, neonatal inpatient, long-term care, and treatment for alcohol and drug abuse and the extent to which existing facilities and services are in need of modernization or conversion to new uses. Similar information would have to be provided on other noninstitutional health services, specifically the number and type of health maintenance organizations and outpatient (including primary care) facilities, rehabilitation facilities, facilities for the treatment of alcohol and drug abuse and other medical facilities and equipment needed to provide public health services and outpatient care.

When Public Law 93–641 was enacted, Congress was concerned about the proliferation of Federal, State, and local planning areas and agencies. For that reason, the law contained language directing each of the planning agencies to coordinate its activities with each PSRO agency, entities designated under section 1152 of the Social Security Act, entities established by OMB circular A–95, as well as State and any other appropriate health entities in the health planning agency's health area. It was hoped that such cooperation would avoid duplication of effort and facilitate implementation of health plans. Unfortunately, sharing of information and data has not taken place to the extent anticipated.

The strengthening of the certificate of need process and other review functions as well as the development of rational health systems plans and annual implementation plans will require increased cooperation between health systems agencies and other Federally mandated or

underwritten data collection agencies. Often, needed data are available from PSRO's, the National Center for Health Statistics, Institutional data systems, and the Federal and statewide reporting components of medicare and medicaid. The committee chose not to include specific amendments to S. 2410, requiring health systems agencies or other agencies to collect additional data, since it was felt that existing statutes already provide authority for the collection and sharing of such data if specific regulations and guidelines for data access can be established by the Secretary on an intra-agency basis. For example, regulation to make the above data available to State health planning and development agencies and through their established authority on an areawide basis to health systems agencies is urgently needed. The committee believes that no bureaucratic obstacles should be imposed by the administrators of Federal health programs to the full availability of such data, and the committee urges the Secretary to promulgate these needed and overdue regulations immediately. PSRO's, hospital cost reports, and other existing data entities have or can develop, under data sharing arrangements with agreed formats, facility-specific aggregate patient data as outlined in section 1513(b) and 1513(b)(2) of Public Law 93–641 and health care cost data as specified in the Medicare/Medicaid Antifraud and Abuse Amendments of 1977 (Public Law 95–142).

Such data might include, but is not necessarily limited to, the following:

(1) The aggregate cost of operation and aggregate volume of services;

(2) The costs and volume of services for various functional accounts and subaccounts;

(3) Rates by category of patient and class of purchasers;

(4) Capital assets as defined by the Secretary, including (as appropriate) capital funds, debt service, lease agreements used in lieu of capital funds, and the value of land, facilities, and equipment;

(5) Discharge and bill data; and

(6) Admissions and length of stay data by type of service, age, sex, diagnosis, area of residence, and source of payment.

Section 118(b) of the committee's bill amends section 1523(a)(4)(b) to require that certificate of need decisions be consistent (except in emergency circumstances that pose a threat to public health) with the State health plan. Currently, certificate of need decisions need not comply with State health plans. Meaningful health planning requires that regulatory decisions meet the objectives included in the health plans at the State and local level.

Section 118(c) of the committee's bill amends section 1524(c)(2)(a) to require that the State health plan prepared by the SHCC have the concurrence of the Governor. The committee intends that the development of the SHP should be a cooperative effort between the Governor and the statewide health coordinating council that will foster a partnership between the Governor and the statewide health coordinating council with the assistance of the State health planning and development agency, as already stipulated in Public Law 93–641. In particular, the term "concurrence" suggests a shared commitment in developing balanced statewide health priorities between the Governor and the statewide advisory council, and recognizes that the Governor

and the statewide health coordinating council both have important roles to play in developing statewide health planning priorities. For example, the continuing cooperative relationship would provide an opportunity for the the chief executive in each State to bring to the attention of the SHCC, fiscal and other priorities of the State government which may have an impact on the State health plan and also to assure that the plan developed by the SHCC conforms with the State's overall health policy.

Section 118(d) of the committee's bill amends section 1524(c)(2) to require that the State health plan contain information similar to that set forth above for the plans developed by HSA's. The State health plan is also to address the resource requirements of manpower, facilities, equipment, and funds necessary to provide access, availability, and quality services at a reasonable cost to persons receiving care within the State. The State health plan should be coordinated with the State mental health plan developed pursuant to the Community Mental Health Centers Act, the State alcohol abuse plan developed pursuant to the Comprehensive Alcohol Abuse and Alcohol Prevention Treatment and Rehabilitation Act, and the State drug abuse plan developed pursuant to the Drug Abuse Office and Treatment Act of 1972.

The committee believes that the keystone to the health planning effort are the areawide health planning agencies; however, the committee further intends that certain functions are more appropriately performed at the State level. Specifically, the integration and synthesis of areawide health plans into a statewide health plan, the establishment of priorities within the State, and the performance of regulatory functions are most appropriately carried out at the State level. The latter function can appropriately be carried out only by an agency of State government. The committee bill is intended to further the establishment of a delicate but workable balance among the varied interests operating in the health care industry today. For that reason, rather detailed and explicit enumerations of the health planning and regulatory functions which can be carried out at the State level are contained in the legislation. To a very great extent, the manner in which those functions are performed is left to the discretion of the individual Governors of the States involved.

Section 119(c) of the committee's bill amends section 1513(b)(2) to require that the health system plan shall include identifiable alcohol abuse, drug abuse, and mental health components, and shall address specifically the needs of all medically underserved populations in the health service area. The committee intends by this provision that special attention be given to the needs of medically underserved populations.

Section 120 of the committee's bill amends section 1513(c)(2) to mandate HSAs to provide technical assistance in obtaining and filling out necessary forms to applicants applying for projects needed to achieve the HSP. Current law provides that HSAs may at their option provide technical assistance, the nature of which has been left undefined. The proposed amendment clarifies the specific type of assistance which HSAs must provide. Addtional technical assistance can and should be provided by the HSA's; however, the committee intended that the HSAs should, at a minimum, provide this type of assistance to all applicants.

Sections 122 (a) and (b) of the committee's bill amend sections 1513 (d) and 1522 (b) (7) (A) to provide that the HSAs and State agencies coordinate their respective activities with entities which review the rates and budgets of health care facilities in their respective areas. The committee intends that the HSAs and State Agencies play a significant role in cost containment efforts and believes that coordination in these areas is important.

Section 123(a) of the committee's bill amends section 1513(g) to further define criteria through which appropriateness review is to be conducted. The committee feels strongly that there must be a meaningful appropriateness review process if the ultimate intent of matching institutional service capacities to levels commensurate with community need is to be achieved.

Section 123(b) of the committee's bill amends section 1513(e)(1)(B) to clarify that grants or contracts under titles IV, VII, or VIII of the PHS Act should not be reviewed by the HSAs unless they are to be made, entered into, or used to support the development of health resources that would make a significant change in the health services offered within the health service area or to support the delivery of health services which would make a significant change in the health services offered in the health service area.

The committee intends that the Secretary shall determine the types of programs supported by grants and contracts under titles IV, VII, and VIII that shall be reviewed by health systems agencies. In making this determination the Secretary shall take into account the importance of the programs to national needs and priorities, the relevance of the programs to the concerns of the health systems agency in planning for its health service area, and the need for timely review of these programs.

The committee does not wish to create an insurmountable administrative burden for HSA's in review of these grants and contracts. It also feels that many such reviews may not be relevant to the interests of the HSA. The committee has therefore, clarified that grants and contracts subject to health systems agency review should be limited to those which cause a significant change in the health services of the area. In the committee's view, the following general guidelines should govern the decision of the Secretary in developing regulations for the HSA's on whether or not to review a grant or contract: (1) Grants and contracts for manpower programs should only be reviewed when the persons being trained will practice primarily in the health service area and significantly affect the supply of health manpower in the area; (2) Grants and contracts for behavioral and biomedical research should not generally be reviewed; (3) Grants and contracts supporting innovation, reorganization, or restructuring of health delivery systems within the Health Service Area should normally be reviewed; (4) Clinical research involving patient care should not generally be subject to review if the patients being treated are subject to research protocols which have been reviewed and approved by the institution's review board, and if the clinical research does not significantly affect the delivery of health services within the health service area.

Section 124 of the committee's bill amends section 1513(g)(1) to focus but not limit the scope of mandated HSA appropriateness review to services included in the State health plan. Current law requires

that HSAs review all institutional health services on a periodic basis, but at least every 5 years. The law does not presently limit appropriateness review requirements to institutional services of a certain minimum size or impact. The committee believes that at present HSAs do not have adequate funds or manpower to review every institutional health service offered in the health service area. Cost effective appropriateness review demands that HSA's first review those services that are the largest or have the most impact. The HSA should review, at a minimum, those institutional health services identified in the State health plan; however, this would not preclude the HSA from reviewing services not so identified, but would ease the burden on the HSAs of reviewing every service.

Section 123(a) of the committee's bill amends section 1513(g) to clarify that HSA appropriateness review should, at a minimum, address the issues of need, accessibility, financial viability, cost effectiveness, costs and charges to the public, and quality of services provided. At present, HSA's functional criteria for review are left unspecified. This proposed amendment defines the scope of priorities which are to be addressed under this type of review conducted by HSA's. Among the purposes of Public Law 93–641 was to improve accessibility of health services for groups traditionally barred from access. This goal is specified as a national health priority in section 1502(1) and is listed as one of the functions of health systems agencies in section 1513(2). Thus the committee intends that the appropriateness of a health service should be considered in light of such additional factors as the accessibility of the health service to low-income consumers. This should include such criteria as the geographic accessibility (in light of the availability of public transportation), economic accessibility (whether or not the facility accepts medicaid or medicare or provides charity care), and physical accessibility (whether an existing facility has been modified to permit access for the handicapped).

The committee wishes to make clear that this provision is not intended to be inconsistent with the stipulation in section 1532(a) that "procedures and criteria . . . may vary according to the purpose for which a particular review is being conducted or the type of health service involved." While each of these issues must be addressed, the way they are addressed may well vary pursuant to section 1532(a).

The committee is aware of current discussions within the Department concerning the role of health planning agencies in assuring that medical facilities comply with Title VI of the Civil Rights Act. The committee wishes to reinforce its previous position that Federal assistance must not be granted to applicants who have not complied with assurances required under Titles VI or XVI of the Public Health Service Act nor who are in violation of the Civil Rights Act, and expresses its concern at the anomalous situation that in cases where a branch of HEW is moving to cut off funding to Federal grantees who violate such obligations the planning process could move ahead to final approval of applications for new Federal grants or to assure future Federal funding of capital expenditures by approval of section 1122 applications.

The solution to this situation lies in better integration of functions and coordination of the separate responsibilities of HEW's office of Civil Rights and of HSA's and SHPDA's. The committee believes

that HSAs and SHPDAs are not appropriate agencies to engage in civil rights investigations or to enforce civil rights obligations. These agencies already have been assigned a demanding set of functions. They do not have the capacity to perform major civil rights enforcement activities at current funding levels. On the other hand, they should receive information regarding civil rights and Hill-Burton compliance from applicants for project review approval and other interested persons and transmit any such information which may indicate a violation of such obligation to the appropriate enforcement agency. If the enforcement agency believes there is sufficient evidence to warrant an investigation, final planning approval of the particular project might be delayed for a short period of time to allow an opportunity for investigation and settlement of the civil rights issue. Such a process would not interfere with the competition of the planning function except for final approval, thereby minimizing potential delay.

In contrast, the committee endorses the Department's efforts to require health planning agencies through their project review authority to focus on issues of access to facilities and to address specifically the contribution of the project in meeting the needs of minorities, women, and handicapped individuals in the health service area.

Section 127(a) and section 127(b) of the committee's bill amend section 1515(c)(1) and 1515(c)(3), respectively, to extend the period of full designation agreements of HSA's from 1 year to 3 years, and to permit the Secretary, if he finds an HSA has not been performing satisfactorily, to terminate it or return it to a conditional status for 1 year, after which time the agency must either be automatically terminated or returned to full designation. The committee believed that extending the period of full designation from 1 to 3 years will enable agencies to enter into more effective long-range planning and outside contracts without the threat of termination hindering their efforts. It will also offer the Secretary an alternative to the extreme option of not renewing the designation agreement.

Section 129(a) of the committee's bill amends section 1516(b)(2)(A)(i) to provide that minimally funded HSAs shall receive at least $250,000 in the fiscal year ending September 30, 1979, and $270,000 and $290,000 in fiscal years 1980, and 1981, respectively. The increase in minimum planning grant is intended to ease the burden of smaller HSAs serving large sparsely populated areas which have experienced budget problems due to high travel costs for board members and staff. It will also help to establish subarea councils where appropriate to meet the planning needs of the health service area.

Section 129(c) of the committee's bill amends section 1516(c)(1) to authorize appropriations of $150 million for fiscal year 1979, $175 million for fiscal year 1980, and $200 million for fiscal year 1981. Increases in the authorization levels will allow for the provision additional funds as the program assumes new and broader responsibilities.

Section 129(d) amends section 1516(c) to provide that of the amounts appropriated for HSAs the Secretary may use not more than 5 per centum of such amounts to increase the amount of a grant to a health systems agency to assist the agency in meeting extraordinary expenses such as may occur in HSAs that serve a large rural or urban

medical underserved population, or in HSAs that are located in more than one State.

These discretionary funds are intended to permit supplemental funding of HSAs for those kinds of extraordinary expenses that cannot readily be reflected by a formula no matter how complex or finely tuned. These might include the so-called high costs of "distance" in sparsely populated but geographically large areas where HSA expenses associated with travel, subarea advisory councils, etc., are relatively greater. Or where additional costs are of necessity incurred by interstate HSAs by virtue of their need to relate to and interact with several State agencies, differing certificate of need program requirements, and the like.

Sometimes the cost of legal defense in a lawsuit against an HSA or certain of its members or staff might prove to be so expensive as to divert significant resources of the agency away from its planning, review, and other mandated activities. Or an HSA might require a small additional amount of funds in order to close down its operations and meet certain outstanding obligations (e.g., severance pay, lease-breaking penalties) if it is being terminated. Additional discretionary funds could thus be made available in such extraordinary circumstances.

Sections 130(a) and 130(b) of the committee's bill amend sections 1521(b)(3) and 1521(b)(4), respectively, to change designation requirement for the SHPDAs from annually to every 3 years and to permit the Secretary the option of returning a fully designated SHPDA to conditional status for nonperformance of its functions for 1 year, after which time the Secretary must either fully designate the SHPDA or terminate its agreement. This change is a logical corollary of the amendment proposed under section 127 pertaining to HSA designation and will insure that State Agencies are afforded the opportunity for long-range planning.

It is of critical importance that the Department institute a systematic program of periodically assessing the performance of both health systems agencies and State Agencies and continuously monitoring their ongoing operations. Such assessment and monitoring clearly also require a system whereby data and information on the structure, governance, and staffing of these agencies, their planning, regulatory and resource development activities and actions, and selected health systems characteristics and changes are reported at least annually by the health planning agencies to the Department in a consistent form and format.

The committee is heartened that a number of health systems agencies have been site assessed in connection with the Department's review of their anticipated applications for full designation or requests for waiver allowing their conditional designation beyond 24 months. It is concerned, however, that only some rather than all agencies were site assessed prior to their full designation (or approval of waiver requests), that there is evidence that close, continuous monitoring of State and local agencies is not carried out effectively in all parts of the country, and that there still is not in place, nearly 3½ years after the enactment of Public Law 93–641, an agency reporting system.

With regard to the absence of an agency reporting system, the committee has several particular concerns. Generally this deficiency

has meant that the Department is handicapped in its management and monitoring of the health planning program and Congressional appropriation and substantive committees, in effect are forced to rely on incomplete, dated, and frequently little more than hearsay information on the structure, operations ,and performance of health systems and State agencies in their deliberations. More specifically, given the number of lawsuits, complaints, and allegations about consumer membership of some HSA governing bodies not being "broadly representative of the social, economic, linguistic, and racial populations" of their health service areas, it is essential that such information, particularly that reflecting on the economic status of such members, be reported.

It is, therefore, incumbent upon the Secretary of Health, Education, and Welfare and the Director of the Office of Management and Budget that they assure the swift development of reporting instruments that will provide needed information. In this regard, the committee wishes to call attention to the 1974 report of the House Committee on Interstate and Foreign Commerce, "The committee is further aware of the appalling difficulty which the program in the Department has had in getting clearance for the reporting system and the forms to be used in it through the Department and the Office of Management and Budget." This situation apparently has not been corrected.

Section 132 of the committee's bill provides than any person who is adversely affected by a final decision of the State Agency pursuant to paragraphs (4), (5), or (6) of section 1523 (a) may, within a reasonable period of time after such a decision is made and any review is made pursuant to paragraph (13), obtain judicial review of such a decision in an appropriate State court.

The committee intends that the term "any person adversely affected by a final decision of the State Agency" will include all persons residing within the geographic area regularly served by the providers involved in any decision or review by a State Agency referred to in this section or persons who regularly use health facilities within such a geographic area. The committee further intends that any person "adversely affected" include any provider in the health service area affected by an agency action, a provider in a different health service area if the proposal under review could adversely affect that provider, and any other person who participated in a proceeding before the agency.

Section 134(a) of the committee's bill amends section 1523(a) to require SHPDA's to provide technical assistance in obtaining and filling out the necessary forms to individuals and public and private entities for the development of projects and programs. The intent of this proposed amendment is consistent with that described under section 120 pertaining to technical assistance to be provided to applicants by HSAs. The committee does not intend, however, that technical assistance be limited solely to this clerical function, but rather that this level of technical assistance be given to all who request it.

Section 134(b) of the committee's bill amends section 1523(a)(2) to require that the preliminary State health plan include an identifiable alcohol abuse, drug abuse, and mental health component which shall be prepared by the respective alcoholism, drug abuse, and mental health authorities, respectively, designated by the Governor. Although various portions of the preliminary SHP may be prepared by agen-

cies other than the SHPDA, the committee intends that the SHCC and the Governor in preparing the SHP will perform the necessary integration of the various components to assure effective delivery of health and mental health services within the State.

Section 135 of the committee's bill amends section 1523(a)(4)(B) to clarify the Secretary's role in approving certificate of need programs, and to add various new provisions that must be included in State certificate of need program. By this amendment, the committee intends to strengthen the integrity of the certificate of need process.

In testimony submitted to the subcommittee, the issue of discrimination against osteopathic facilities and services in the certificate-of-need process was raised by the osteopathic profession.

The potential for such discrimination was recognized by the Secretary in promulgating regulations implementing the certificate-of-need provision of Public Law 93–641. The testimony from the osteopathic profession indicated that actual discrimination has occurred.

While the committee does not at this time believe that separate consideration for osteopathic facilities and services should be mandated as a minimum criteria for State certificate-of-need programs, nothing in this section should be interpreted to preclude States and HSAs from according such consideration.

The committee further urges the Secretary to continue to monitor HSA and State review activities carefully to assure sensitivity to the needs of osteopathic patients for services and facilities within health service areas.

Section 141 of the committee's bill amends section 1531(5) to broaden State certificate of need requirements to include expensive equipment regardless of location. Items of diagnostic or therapeutic equipment acquired through purchase, rental, lease, or gift with a value over $150,000 would be covered by the proposed amendment. The present authority restricts Federally-mandated State certificate of need coverage to "new institutional health services". This leaves a large loophole which is increasingly being used by some individuals to acquire certain kinds of highly expensive equipment. This omission from certificate of need coverage has been a major problem area and an increasing source of concern. The inclusion of all expensive equipment, regardless of location, is necessary for the coordinated utilization of existing services and to protect against the unnecessary proliferation of services connected with expenditures which are presently exempted from review. The committee received a great deal of support for this amendment including the endorsement of the American Hospital Association, the National Council of Community Hospitals, the Washington Business Group on Health, the United Auto Workers, the Consumer Coalition for Health, the AFL–CIO, the American Health Planning Association, and many others. The committee found the testimony of the National Council of Community Hospitals was particularly persuasive on this point. Their testimony said, in part:

> As this committee is well aware, one of the major loopholes and counterproductive features of the existing act has been the interpretation by HEW that it applies to the purchase of medical equipment only by institutional providers. As a result of this, there has been a proliferation of equipment located

outside and independent of hospitals. Because physicians' offices and clinics are considered not to be included within the act, they have been able to purchase expensive equipment free of review by the planning agencies. As a result, equipment which rightfully should be centralized for the use of the whole community in the hospital is being dispersed in a number of unnecessary and duplicative facilities. The act should be amended to make it clear that all purchasers of equipment are equally subject to planning review.

We believe that the approach taken by section 141 of the bill well effects that purpose. Rather than amending the act in each place to change the term "institutional health services," it specifies that the purchase of equipment in excess of $150,000, by whomsoever, is a new institutional health service and therefore subject to certificate of need legislation. The purpose of this provision is clear and its effect is also clear. The Planning Act will, if this language is adopted, require the states to review purchases of expensive equipment by physicians, clinics, and others, as well as by hospitals. We strongly support this provision.

Since the executive session at which time the committee's bill was ordered reported, the prestigious Center for the Analysis of Health Practices at the Harvard School of Public Health of Harvard University has forwarded its compilation of recent data on the proliferation of CAT scanners in doctors' offices. Their most recent study indicates that there are 713 CAT scanners owned by hospitals in hospitals, 46 CAT scanners privately owned in hospitals, and at least 112 in the private offices of physicians. Although the last number may be an underestimate because it includes only those scanners that planning agencies know to be in physicians offices, almost 15% of the total are in private offices, and there are indications that unless this loophole is closed that percentage will rise.

Section 141 of the committee's bill would provide that in determining whether or not equipment is valued in excess of $150,000, the "value of studies, surveys, designs" et cetera must be included. The committee has chosen to use the term "value" (rather than "cost") so that the computation of the $150,000 limit will include the value of all the specified preliminary work even if such work is done by the applicant itself and the applicant does not purchase those services from an outside source. This provision is essential. It is intended to prevent situations where certain institutions (e.g. chain proprietary hospitals) which have the financial capability of doing their own planning would be subject to a different calculation of the threshold amount than other institutions such as community hospitals which do not have that capability and must contract with consultants and others to obtain the necessary information.

The committee in its study of the certificate of need process was disturbed by program policy notice 78–18 issued February 14, 1978, by the Bureau of Health Planning and Resources Development which stated in part:

> The certificate of need program regulations at section 123.407(a)(10) require that State certificate of need pro-

grams give to persons proposing new institutional health services the right to appeal "any decision" of the State Health Planning and Development Agency (SHPDA). A question has arisen whether the failure of a SHPDA to make its decision within the required period of time, which has the effect of a finding of no need (see § 123.407(a)(15)), can be considered a "decision" for purposes of section 123.407(a)(10). The effect of § 123.407(a)(10) and (15), when used together, is that the SHPDA's failure to act is a decision on which an appeal may be based. The effect on the applicant is the same whether the SHPDA expressly denies an application or fails to act on it. As a result, when the SHPDA fails to act on an application, the person proposing the new institutional health service is entitled to the appeal rights provided in section 123.407(a)(10). Similarly, this right would be available to the health systems agency under section 123.407(a)(9).

The committee believes that any State Agency which holds itself out as capable of administering a State certificate of need program, should be competent to review the required applications in a timely and efficient manner, and that the current "pocket-veto" provision of the regulations promulgated attendant to P.L. 93–641 fails every test of fairness and is the very antithesis of due process. The committee intends that the Department correct this shortcoming and work with the State Agencies to assure that reviews are made in a timely fashion.

Sections 137(a) and 137(b) of the committee's bill amends section 1524(c)(1) and section 1513(b)(2) respectively, to direct the SHCC to establish in consultation with the HSAs and the State Agency a uniform format for HSPs and AIPs. Current law requires the SHCC to develop a State health plan based on the various HSPs submitted to it by the HSAs. This proposed amendment would establish a basic consistency in the form of the plans submitted by the HSAs and would aid considerably in the process of developing a State health plan. The committee believes that this amendment should also help forge closer linkages between the HSAs, the SHCC, and the SHPDA.

Section 140(b) of the committee's bill amends section 1531(3)(B)(i) to allow consumers who serve on boards of other health organizations and agencies to be considered as consumers, rather than indirect providers, for the purpose of this act. The current definition of indirect provider prevents many individuals who might otherwise be considered among the most informed potential candidates from participating as consumers on HSA boards. This particular restriction has met with widespread criticism from individuals, planning bodies, and organizations concerned with implementation of the program. The intent of this proposed amendment is similar to that described under section 110. When linked to the proposed expansion of conflict of interest provisions set out in section 104, the committee believes there to be little reason to preclude such individuals from consumer membership.

Section 142 of the committee's bill amends section 1532(a) to stipulate that procedures and criteria for review by HSAs and State agencies must provide that applications be submitted in accordance with established timetables, that reviews be undertaken in a timely fashion, and that applications for similar types of services, facilities, or organizations be considered in relation to each other no less often

than twice a year. This section also provides that HSAs and State Agencies must cooperate in the development of procedures and criteria to the extent appropriate to the achievement of efficiency in their reviews and consistency in criteria for such reviews. The committee believes that this batching of similar applications when done as a coordinated effort between health systems agencies and State Agencies as envisioned will result in careful comparative review of services as a function of established planning priorities and will also promote more equitable decision-making at the health systems agency and State health planning and developing agency levels.

Section 143 of the committee's bill amends section 1532(b) to provide that for HSA and State Agency review of certificate of need applications and review of appropriateness of services, each participant may present evidence and arguments orally and/or by written submission; that there is opportunity for each participant to cross examine other participants who make a factual allegation relevant to such a review, that a hearing record be maintained; and that the HSA and State Agency decisions be based solely on the hearing record. There is also a prohibition on ex-parte contacts with individuals voting on the review process.

The committee believes that the review process must guarantee the essential ability to cross-examine witnesses. The committee believes that a hearing could be a meaningless process if witnesses are permitted to make statements that cannot be tested either for their factual validity or for the interest which may underlie them. The committee, however, does not believe that cross-examination should apply to persons who are merely stating their position on a matter before the HSA or the State Agency, and not making specific factual presentations.

The committee intends that the provision for maintaining a record should include a reporter's transcript of the proceedings. The committee does not feel that the HSA or the State Agency should determine for itself what record to keep. It fears that, if such were allowed, the resulting record might be limited to written submission, whereas the most important probing of the validity of applications is likely to be done orally, particularly upon cross-examination. The committee believes that the requirement that any decision be made on the basis of the record established at the hearing will insure fairness for all interested parties. Clearly, this requirement is not intended to preclude the ability of the reviewing agency from taking "judicial notice" of relevant facts, where appropriate.

The committee is concerned that, in the administration of present hearing and intends that current HEW regulations which provide that an HSA hearing satisfies the requirement that the SHPDA hold a hearing, 42 CFR § 122.306(a)(7) and § 122.407(a)(7) be immediately modified. The committee believes that the issues before the SHPDA may not necessarily be the same as those before the HSA and that the HSA's recommendation in itself adds a new factor into the planning consideration which must be evaluated by the SHPDA. Interested persons should be able to obtain a hearing on the issues raised by the HSA's recommendation.

The committee is concerned that, in the administration of present section 1524(c)(6), action taken by a SHCC to disapprove a State plan or application can cause an immediate withholding of Federal funds and an interruption of ongoing programs. The committee urges

the Department to administer this provision in such a way as to assure that sufficient time is allowed for action by the SHCC and for any subsequent revisions in a plan or application which may be necessary in order to qualify for funds before the date on which the funds would be awarded. The intent of the language in the law is not to give the SHCC a veto over a State plan, but to give the SHCC an appropriate opportunity to review a plan or application as part of a process to achieve conformity with the State health plan.

Section 147(a) of the committee's bill amends section 1532(c)(9)(B) to provide that in the case of a construction project, HSA and State Agency review will consider the probable impact of the project on the costs and charges of providing health services not only by the person proposing such construction project (as currently provided) but also "on the costs of providing health services by other persons."

Section 147(b) of the committee's bill amends section 1532(c) to provide that in addition to existing criteria the HSA and State Agency shall consider in the case of existing services or facilities, the quality of care provided by such services or facilities in the past, and the extent to which such proposed services will be accessible to all the residents of the area to be served by such services.

Section 1502(6) of Public Law 93–641 established as a national health priority the achievement of needed improvement in the quality of health services. Section 1513(a)(2) similarly established as a function of the health systems agency improvements in the quality of health services. Thus, the committee believes that in light of these stated goals, it would be incongruous to award a certificate of need to a facility that has been providing substandard care in the past so that it could provide expanded substandard care in the future. For this reason, section 123 includes quality of care as a criterion of appropriateness review. Efforts of some health systems agencies to include quality of care as a criterion in certificate of need review have been largely unsuccessful to date. The committee's action is intended to reinforce these efforts and underscore its concern in general with the quality of care issue.

Health systems agencies are required by section 1513(d) to coordinate their activities with professional standards review organizations in the health service area. This is to avoid duplication of efforts to participate in PSROs as a result of the Court's decision. The comand to assure that the findings of the PSRO and other evidence will be utilized in the health planning process.

The committee notes the recent ruling in *Public Citizen Health Research Group* v. *The Department of Health, Education, and Welfare* civil number 77–2093 (D.D.C., memorandum in order, April 25, 1978) which stated that professional standards review organizations (PSROs) are federal agencies subject to the Freedom of Information Act (FOIA).

The District Court held that PSROs are performing a public function and possess substantial decision-making authority with regard to medicaid and medicare and thus should not be exempted.

This Committee is [well] aware that some sensitive PSRO data should not be subject to general public disclosure because it violates the privacy rights of both patient and provider. But the committee is also concerned that certain agencies, such as the State and local

health planning agencies and [even] the Department of Health, Education, and Welfare have been denied access to PSRO data. The committee is concerned that in many cases the PSROs have been reluctant to even discuss ways to assure access to agencies with a legitimate need while at the same time protecting personal privacy.

The committee recognizes that many physicians may be reluctant to participate in PSROs as a result of the Court's decision. The committee is concerned at the adverse reaction by physicians but is also concerned about the degree of non-cooperation between the PSROs and other federally-funded health planning agencies when cooperation is clearly in the national interest. The committee is prepared to work with all interested parties to assure that the personal privacy rights of physician and patient is protected while at the same time assuming access to PSRO data to those with a legitimate need.

The denial of access to low-income and minority persons has been a focus of increasing concern to the committee. The extent of this problem has been documented in a report of the Congressional Budget Office and in testimony from the Georgia Legal Services Corp. While health care costs have continued to rise at an alarming rate, there has been a simultaneous recognition that many individuals still do not have access to basic health care. In many communities according to testimony received, women are compelled to agree to sterilization procedures before providers are willing to provide other treatment. In many other communities, such basic services as obstetric and gynecological services are simply unavailable under any circumstances.

Congress established as one of the functions of the health systems agency to increase the accessibility of health services. Certificate of need and section 1122 review are therefore to be conducted on the basis of the general need in the community for the health service to be provided. The person proposing a particular service, however, may by policy or practice exclude significant portions of the consumer community from access to the facility. The need for the health services should therefore only be considered in light of the population which may be ultimately served by the facility.

Under existing provisions of Public Law 93–641, health maintenance organizations are subject to certificate-of-need requirements for virtually all phases of their operation. The activities of fee-for-service physicans, on the other hand, have been seldom covered by State CON laws.

The committee views with great concern a growing body of evidence that the planning process has seriously handicapped HMO development. Among the original purposes of the Health Planning Act was the encouragement of cost containment in the fee-for-service system through more efficient allocation and management of health care resources. In contrast to the fee-for-service system, health maintenance organizations contain internal cost containment incentives and have proved their ability to reduce health care costs. Despite this exceptional capacity to serve the overall goals of the planning process when allowed to operate properly, testimony before the committee revealed repeated instances of misunderstanding of the HMO concept and discrimination against HMO certificate-of-need applications at the HSA and State Agency levels. This evidence indicates that HMOs, because they compete with the fee-for-service system, are frequently given

unobjective appraisals of CON applications by provider-dominated HSAs. This situation occurs particularly because HMOs are usually new entrants into an area and do not enjoy the presumptions benefiting the status quo under the planning process.

It was clear to the committee that this situation required remedy, and section 147(c) of the committee's bill requires that State certificates-of-need laws cover HMOs no more restrictively than fee-for-service providers. In order to assure fair appraisal of HMO certificate-of-need applications, however, the bill sets forth certain limited criteria that must be used in processing qualified HMOs applications for the purchase of equipment costing more than $150,000 and for new inpatient hospital facilities. The committee emphasized that these criteria are to be the sole criteria utilized in processing such applications. HMO certificate-of-need applications must be judged on the basis of these standards and no other, except to the extent that additional standards conform with the criteria regarding the relationship between HMOs and health planning programs set forth in the conference report accompanying H.R. 9019, 94th Congress, 2nd Session (the Health Maintenance Organization Act Amendments of 1976).

In limiting the special new certificate of need criteria added by section 147(c) to federally qualified HMOs that wish to provide new institutional health services, the committee does not intend to restrict HSAs and SHPDAs in their ability to give special CON consideration to other types of HMO's. It should be noted that section 1532(c)(8) still contains a requirement that HSA and State Agency CON criteria include consideration of "the special needs and circumstances of health maintenance organizations for which assistance may be provided under title XIII", and that such consideration need not be limited to Federal qualified HMOs.

Section 148(a) and Section 148(b) of the committee's bill amend section 1534(a) and section 1534(b)(1) to require the Secretary to enter into grants with the centers for health planning, rather than allowing the existing option of grants or contracts. By revising the funding provisions to include grants only, the proposed amendment would enable centers to respond flexibly to the changing needs of planning agencies and to engage in a wide variety of activities without being subject to the kinds of limitations presently imposed under contract arrangements, whereby a center can perform only those services specified in the contract.

In the passage of Public Law 93–641, Congress opted for a system of planning and regulation in the health field that focused on broad participation by all segments of the community. To make this broad participation effective, the committee intended that there must be strong support for consumer and many provider members on SHCCs and HSAs. The interests of the many groups represented are far from self-evident given the technical complexity of the health planning process and the volume of materials which must be digested by board members. The committee feels that if training is not made available on the basic issues and options in health care, then many members will find it difficult to represent the interests of the various groups or constituencies in the community.

Section 148(c) of the committee's bill thus amends section 1534(c)(2) to require the types of assistance and dissemination of informa-

tion to HSAs and State Agencies explicitly set forth in subsections (a) and (c) of section 1534 in order to be eligible for grants from the Secretary. This amendment adds an important new requirement that would mandate that the centers develop and disseminate methodologies to provide for the initial and continuing education of new board members and staff of the HSAs and new staff of the State Agencies.

The committee is particularly concerned that the training go beyond the technicalities of the health planning law and include such areas as:

(*a*) Disease prevention;

(*b*) Public and environmental health;

(*c*) The impact of these practices on uitilization and long term cost control;

(*d*) Short term cost control measures;

(*e*) Factors contributing to excessive and inappropriate medical procedures and facility utilization.

(*f*) The special circumstances and needs of rural and urban medical underserved populations.

Section 152 of the committee's bill amends section 1513(c) to provide for Indian self determination as related to health planning, and requiring that when a health systems agency is requested to review a proposed use of Federal funds, other than those specified in section 1513(e)(1)(A) to support the development of institutional health services intended for use in the health service area, the health systems agency shall, within 60 days of receiving such a request, submit its views on such proposed use to the Federal department or agency involved and to the appropriate committees of Congress.

This provision clarifies the relationship between Indian tribes and HSAs, under the Public Law 93–641 planning process, and the relationship between this Act and two recently adopted pieces of Indian legislation—the Indian Self-determination Act (Public Law 93–638) and the Indian Health Care Improvement Act (Public Law 94–437). Indian tribes have expressed concern that confusion in this area has led to conflict between tribes and HSAs and has inhibited full tribal participation in the health planning process. It is the policy of the Congress, as expressed in this provision, that Indian tribes remain the sole authority for health planning and development on their reservations. In addition, tribal participation in the national planning process shall be promoted through the development of cooperative agreements between tribes and HSAs on matters of mutual concern.

This provision makes clear that Public Law 93–641 did not give HSAs any authority over Indian tribes, reservations, or Indian health planning activities. Pursuant to the Indian Self-determination policy, tribes retain their exclusive authority to plan for and develop health programs for their members. Pursuant to the Indian Health Care Improvement Act, tribal specific health plans are the official planning instruments for Indian health programs. These plans shall be incorporated into the HSP of the relevant HSA; the HSA and State Agency shall have no authority to alter or amend them. The committee expects the Secretary to enact regulations to implement this policy. In addition to addressing the issue of HSPs, the regulations shall implement this policy in all other areas where HSAs and tribes come into contact. For example, regulations shall provide that tribal requests for certificates of need shall be granted if the requested facility

has been approved by the tribal health planning entity, and that HSA comment under the review and comment provision (1513(e)(B)) shall be limited to comments on those matters which have a substantial impact on non-Indian health facilities or programs.

This committee also believes that cooperation between HSAs and tribes will improve the planning activities of both entities. For example, HSAs need to know projected Indian utilization of non-Indian hospitals under the IHS contract health care program. Therefore, the provision also mandates the Secretary to develop regulations to promote this necessary cooperation. Rather than dictating the nature of this cooperation, the Secretary should develop model agreements that tribes and HSA could use as a starting point for their agreements, and should encourage and assist HSAs and tribes to work out arrangements on their own. The Secretary shall become involved directly in negotiations on such agreements only when the local entities have been unable to work out an agreement by themselves.

Finally, tribes expressed a compelling need for funding and technical assistance to enable them to improve their health planning capabilities. The committee believes that one or more of the centers for health planning, created by Public Law 93–641, should devote some of their resources to assist tribes in this area. With regard to funding, the 1978 amendments to Public Law 93–641 empower the Secretary to increase planning grants to HSAs which have extraordinary expenses. The Secretary shall review the planning needs of tribes to determine whether HSAs which have tribes located within their areas should be given increased planning grants, with the increased funds to be passed on to the tribes for use in tribal health planning activities. There shall be maximum Indian and HSA participation in the development of all regulations issued pursuant to this provision.

The committee feels it is important that mental health planning be emphasized both at the State and local level and that appropriate mental health goals and objectives be reflected in the plans developed by the State and health systems agencies. It is equally convinced that mental and physical health planning should be accomplished as a part of an integrated process.

The reported bill amends the Health Planning and Resource Development Act of 1974 to include two additional Congressional findings and purposes which specifically address the need to coordinate mental health planning with the health planning law.

While existing law left implicit the inclusion of mental health planning within the health planning process required of each State and locality, unfortunately, mental health planning at the State level has been oriented generally toward meeting Federal requirements for grant support under the CMHC program and has concentrated on the allocation of public dollars to largely publicly-operated programs. For the most part, it has not been addressed to formulating and achieving broad mental health goals or to guiding resource allocations in the private sector.

The committee believes there is general agreement that health is not merely the absence of illness or infirmity but rather the overall wellbeing of the individual. Consumers have shown dissatisfaction with a health system which compartmentalizes their needs and requires them to seek different types of service in different locations.

Throughout the committee's bill, reference is made to "health and mental health." The committee intends that such references include alcohol and drug abuse.

A key aspect of care that has been particularly weak in the traditional system is the integration of physical with mental health. Health planning activities for these two categories of care have progressed along distinct lines with problems of prevention, diagnosis, rehabilitation, financing, etc., handled discretely by each system. The committee is concerned that the result has been delivery systems for health and mental health that have promoted fragmentation, lack of continuity and inappropriate utilization. The committee believes that by bring the planning aspects together, the integration of all physical and mental health service delivery, including care and treatment for alcohol and drug abuse, will be fostered.

Consistent with the addition of two findings and purposes which intend to integrate mental health planning into the health planning law, three new national priorities have been identified in the reported bill. The first addresses the need to approach planning in a holistic manner—recognizing the direct relationship between physical and mental wellbeing. The second and third priorities stress the need to assure appropriate placement and high-quality care for those in need of inpatient mental health facilities, and to emphasize the provision of alternative types of outpatient service for all of those for whom institutional care is not appropriate.

The committee wants to emphasize the need for planning efforts to encompass the private as well as the public sector of mental health care, and for this reason, specifically addresses the issue in the last of the three national health priorities. The committee is cognizant of the fact that the private sector had not been included in mental health planning to the extent that it could be viewed as an alternative care milieu to the public sector. In attempting to bring mental health care within the health planning law, the committee believes all appropriate settings—public and private—should be incorporated in the effort to assure quality and access to mental health care for all Americans.

To further the integration of health and mental health planning and to assure quality health systems agency plans, the committee's reported bill has proposed that individuals with expertise in mental health planning and resource development be included on HSA staff. While the committee does not mandate that a certain number of such staff be included, the magnitude of need for mental health services and the Federal dollars involved clearly indicate the need for such expertise. The committee is confident that the Secretary of HEW will make appropriate efforts to assure that such expertise is represented adequately on HSA staff.

While the committee has not altered the composition of HSA governing bodies or of the SHCC, it is cognizant of the need to infuse expertise in mental health planning in both consumer and provider members of such bodies. It is the committee's hope that with the natural attrition over time of HSA governing body members and SHCC members, that serious consideration will be given to including mental health care consumers and providers as vacancies occur.

The committee, as part of its continuing oversight function, will review from time to time the adequacy of mental health representa-

tion on HSA governing bodies and on the SHCC to determine if in the future such specific amendments are necessary.

While HEW guidelines speak to the need for coordination by HSAs with mental health, alcohol abuse and drug abuse planning agencies, the committee intends to assure that this essential coordinating function is carried out in the most appropriate manner. It has, therefore, included such functions within the required activities of the HSA in the reported bill.

Statewide mental health and alcohol abuse and drug abuse plans are mandated by State government in virtually all States. Such State mental disability planning is ongoing irrespective of any Federal health planning requirements. The cost of such mental disability planning is presently borne in full by State government.

Independent State mental health and alcohol abuse and drug abuse plans have been mandated in recent years because public expenditures for mental health and alcohol abuse and drug abuse have risen to where they are now 40 percent of all expenditures in the States for public health.

Yet, only a small portion of these public health expenditures for mental disability programs are subject to review and control under the provisions of Public Law 93–641.

Thus, the goal of Public Law 93–641 is partially circumvented, and its objectives cannot be fully implemented, if mental health and alcohol abuse and drug abuse planning components continue to be developed in the States independently and are not incorporated into the Statewide health plan.

Representing as they do, forty percent of the public health expenditures in the States, it is administratively practical that the State authorities for mental health and alcohol abuse and drug abuse be delegated the responsibility for (a) aggregating and revising the relevant provisions of the HSPs and (b) preparing the corresponding mental health and alcohol abuse and drug abuse components of the preliminary State mental health plan.

With such a collaborative effort with the SHPDA, the committee expects that the integration of mental health and alcohol abuse and drug abuse components into the preliminary State health plan will, among other things:

(a) Assure a more efficient deployment of State dollars in the care and treatment of the mentally disturbed and alcohol and drug abusers;

(b) Assure an appropriate redistribution and utilization of excess general hospital beds to facilitate Federal and State objectives in deinstitutionalization of those mental patients still inappropriately cared for in large institutions;

(c) Put proper controls on aftercare and followup services for the mentally disabled and alcohol and drug abusers; and

(d) Improve accountability in community mental health support services encouraged and supported by the Congress.

Section 201 of the committee's bill amends section 1603(a)(3) to require that the Governor as well as the statewide health coordinating council approve the State medical facilities plan. This conforms with the requirement that both the SHCC and the Governor must approve the State health plan. The committee intends that no expenditures be

made for construction or modernization that are inconsistent with an approved SHP.

Section 202 of the committee's bill amends section 1613 to authorize the Secretary to make funds appropriated for use in fiscal year 1976 under section 1613, but not expended, to be used for the purposes spelled out in section 1625(d):

Until last year funding for 1625(d) depended upon a 22 percent set-aside of funds appropriated for all hospital construction under the act. Unfortunately since the enactment of Public Law 93–641 no such funds have been appropriated, and the 22 percent set-aside has been limited to about $11 million, which was the required share of carryover funds.

Section 204 of the committee's bill amends section 1625(d) to authorize appropriations for grants for construction or modernization projects under section 1625 as follows: $75 million for fiscal year 1979, $100 million for fiscal year 1980, and $125 for fiscal year 1981.

The committee notes that 3 out of 10 hospitals are owned by State or local government. Often these hospitals provide access to care for those who are unable to utilize private facilities due to geographic or social barriers. In large urban areas, the public general hospital has had the historic function of serving the poor.

In addition to its different clinetele, the public general hospital also provides a somewhat different array of services. Often, it is the only hospital willing to treat alcoholism and drug abuse cases. A recent study of large urban hospitals indicated that they also provide three times more outpatient services relative to their inpatient workload than average community hospitals of comparable size.

This mix of services has caused serious financial problems for the public general hospital. Patients in the urban public general hospital are often the poorest and most seriously ill. Third-party payment often fails to meet their expenses and the limited local governmental tax base must provide the resources to fill the gap. Rural public and other general hospitals suffer from third party payment rates which are lower than urban rates.

The financial problems of local government make it difficult to raise capital for needed reconstruction or renovation of the public general hospital. Tax revenues often cannot meet their needs, and localities often must borrow at extremely high interest rates. In some cases, localities are excluded from the bond market altogether. Often the physical plant is old and renovated only with extreme difficulty. Yet renovation is necessary if the hospital is to meet required life safety codes. While the committee is concerned with the problem of overbedding and its cost implications, it also feels that Congress must consider the special services and problems of these urban facilities. One facility that typifies these special needs is the Harlem Hospital Center in New York City, whose application for assistance under this section is pending the appropriation of additional funds.

These funds are to be used to help the public general hospital meet and maintain minimum life safety code standards and other licensure requirement. Presently, there are 53 urban and rural project grants which have been approved for funding at a total of $200 million; yet presently available resources will allow the funding of only four projects at a cost of $11.3 million. The committee intends that the re-

programed funds under section 1613 be made available as rapidly as possible for these purposes, and that the Secretary use due haste in completing his review of applications for these funds.

The committee stresses, however, that local HSA's must take a close look at all proposed construction and renovation proposals to avoid the possibility of duplication. In this regard, a significant problem is the lack of attention in the planning process to the immediate need to reform the organization and delivery of primary care and institutional health care services in medical underserved areas. In addition to making good use of the resources that are provided for in section 1625(d) for the renovation and modernization of public hospitals, HSA's must move ahead immediately to target their efforts on the problems of medical underserved areas. The developmental funds provided for HSA's under section 1640 should be first targeted on initiatives to increase accessibility, availability, and quality of medical care for medical underserved areas.

Section 206 amends title XVI of the PHS Act by establishing a program of financial assistance to encourage the voluntary consolidation of duplicative hospital services and the voluntary discontinuation of unneeded hospital services. Any hospital in operation on the date of enactment of this act and which intends: (1) to discontinue providing all inpatient health services could apply for a debt payment and an incentive payment for this discontinuance; (2) to discontinue an identifiable unit of the hospital that provides inpatient health services could apply for an incentive payment; or (3) to convert an identifiable part of the hospital into providing long-term care services, ambulatory care services, or any other service designated by the Secretary could apply for a conversion payment if the SHPDA has determined, after considering recommendations of the HSA, that such service is needed.

These incentive payments could, under the committee's bill, be used for the planning, development (including the cost of construction and acquisition of equipment), and delivery of ambulatory care services, home health care services, and long-term care services designated by the Secretary. Incentive payments could also be used, in cases where the applicant has merged with another hospital, for preparation of that hospital to serve patients of the closed hospital and such payments could also be used for reasonable termination pay for personnel who lose employment because of discontinued inpatient services, or for retraining such personnel and assisting them in securing employment.

Applications for such employment would have to include:

(1) a description of the service or services to be discontinued or converted;

(2) an evaluation of the impact of such action on the health systems in the area;

(3) an estimate of the change in the applicant's revenues that would result from such discontinuances or conversions;

(4) a description if all services are to be discontinued, of the activities for which payment is intended, the means and manner in which the applicant will carry out such activities, the amount meant to be expended for such activities, and the person responsible for making such expenditures;

(5) a description of the use the applicant will make of any incentive payments for discontinuance of an identifiable unit of a hospital;

(6) an evaluation of the impact of such discontinuance or conversion on the employees of the hospital; and

(7) other information as the Secretary may, by regulation, require.

In accordance with criteria developed under section 1532(c), the HSA would be required to determine the need for the service to be discontinued or the part of the hospital to be converted. The HSA would then make its recommendation to the SHPDA which would make its recommendation to the Secretary. The Secretary could not approve an application which a State agency has recommended against.

In the committee's bill, the debt payment to be made to a hospital that is discontinuing all its services would be a sum consisting of the lesser of (a) the total outstanding financial obligations attributable to the equipment and facilities of the hospital, or (b) the amount of unexpended depreciation attributable to such equipment and facilities, less the fair market value of the equipment and facilities, plus any other debt expenses resulting from the financial obligation of the applicant being satisfied before due.

Incentive payments for discontinuance of all services would include an amount not in excess of the amount reported by the hospital under section 1642. If a hospital is discontinuing a unit, the incentive payment would equal 30 percent of the charges reported as attributable to that unit in the previous hospital accounting fiscal year.

Conversion payments would equal 50 percent of the reasonable cost of conversion approved in the application. The debt, incentive, and conversion payment would be paid in a single payment. Health systems agencies would receive 10 percent of any incentive payment that is due any facility or facilities in the agency's area. The HSA could use this payment only to make grants and contracts in accordance with section 1513(c)(3) for projects and programs within the community served by such hospital, or if such community does not need any such project or program, within another community.

The Secretary is directed to make a study of the first 25 applications approved under this section and report the results of such study to the Congress, together with his recommendations for any revisions in the program which he determines to be appropriate, including any revisions in the authorization of appropriations for such program. As with any new program, the committee expects that modification will be needed after the program has been in operation for some time. It anticipates receiving in a timely manner the study called for in this section.

The committee intended in drafting this section of the bill to address the problem of excess capacity in the health care system, which contributes unnecessarily to the high costs of the medical care. If the 100,000 excess beds were to be closed, a reduction of about 10 percent of the total existing complement, considerable savings would accrue to the system on an annual basis. Various estimates have indicated that the amount of the savings will depend on how the beds are eliminated:

> If the capacity is reduced 10 percent by closing or converting whole hospitals, there will be an estimated savings of about 8 percent of total hospital expenditures. Annual savings would be $40,000 per bed or a total of about $4 billion based on 1976 expenditures.

If the 10-percent reduction results from closing particular service departments, the savings will be an estimated 4 percent of total expenditures. Annual savings would be $20,000 per bed or a total of about $2 billion.

The savings from closing scattered beds would be minimal.

There have been numerous suggestions that the health planning program deal with the problem of excess capacity through a mandatory decertification authority to be added to the existing mandate for certification of proposed new institutional health services. The approach envisioned in the proposed amendments, however, is purely voluntary in nature and depends for its success upon the cooperation of both providers and planning bodies. It would remove the hospital's primary financial barrier to closure—outstanding debt—and provide other incentives for the development of alternative health services for the community in which the closing hospital is located. It would also recognize and deal with other concerns associated with hospital closure, such as the impact on employment.

While the committee believes that the reduction of excess hospital bed capacity is an important public policy objective, and that the availability of debt, conversion, and incentive payments is a rational and fair means of facilitating the objective, it is concerned that these voluntary incentives could create the situation in some communities that needed but politically and financially vulnerable services, such as those provided by the public general hospital, might be attempted to be phased out. It is not uncommon for hospitals to close departments or phase out services which are in and of themselves unprofitable, even though the facility's overall financial health may be sound. These closures or phaseouts can be particularly devastating for the poor if, as is often the case, the clinics or departments involved are the source of scarce emergency room or outpatient services.

Similarly, the committee has observed that over the past several years a pattern has emerged whereby private hospitals located in low-income inner-city neighborhoods either transfer their facilities to outlying suburban areas or establish satellite facilities in suburban areas which then drain needed resources away from inner-city communities. The result is a denial of access to needed services for the poor and minorities.

The committee intends that the guidelines for the disbursement of the incentive payments should assure that the facilities and clinics on which the poor and minorities rely for inpatient and outpatient care are not discontinued.

VII. Congressional Budget Office—Cost—Estimate

May 15, 1978.

1. Bill number: S. 2410.
2. Bill title: Health Planning Amendments of 1978.
3. Bill status: As ordered reported by the Senate Committee on Human Resources on May 4, 1978.
4. Bill purpose: To authorize appropriations for titles XV, National Health Planning and Development, and XVI, Health Resources Development, of the Public Health Service Act. Authorizations are for fiscal years 1979–1981.

27-409 O - 78 - 6

Title XV established national guidelines for health planning through the creation of health service areas, health systems agencies, and statewide health planning and development agencies. S. 2410 makes a number of amendments to the title in such procedural and technical areas as designation of health systems areas, certificate of need programs, confidentiality requirements, certification limits, and designation of health system agencies. The bill also authorizes appropriations for health planning grants. State health planning and development agencies, rate regulation programs, and centers for health planning.

Title XVI continues the authority for a program of State allotments for medical facilities construction, the hospital loan and loan guarantee program, and the grant program for area health services development. Project grants to eliminate safety hazards or avoid non-compliance with accreditation standards are also authorized. And, finally, a grant program to encourage the reduction of excess hospital capacity is authorized.

5. COST ESTIMATE

[In millions of dollars]

	Fiscal year—				
	1979	1980	1981	1982	1983
Authorization level:					
Title XVI:					
Planning grants (1516–c–1)	150.0	175.0	200.0	----------	----------
State health planning and development (1525–c)	40.0	45.0	50.0	----------	----------
Rate regulation (1526–e)	6.0	7.0	7.0	----------	----------
Centers for health planning (1531–d)	12.0	15.0	18.0	----------	----------
Title XVI;					
State allotments (1613)	135.0	135.0	135.0	----------	----------
Project grants (1625–d)	75.0	100.0	125.0	----------	----------
Area health services development (1640–d)	120.0	150.0	180.0	----------	----------
Reduction of excess capacity (1643–g)	150.0	200.0	250.0	----------	----------
Total authorization levels	688.0	827.0	965.0	----------	----------
Projected costs:					
Title XV:					
Planning grants (1516–c–1)	54.0	159.0	184.0	128.0	----------
State health planning and development (1525–c)	12.0	41.5	46.5	35.0	----------
Rate regulation (1526–e)	3.0	5.0	6.8	3.5	1.7
Centers for health planning (1531–d)	2.4	10.2	15.0	13.8	3.6
Title XVI:					
State allotments (1613)	20.3	74.3	114.8	114.7	60.7
Project grants (1625–d)	15.0	65.0	100.0	95.0	25.0
Area health services cevelopment (1640–d)	45.6	111.0	150.3	105.0	29.1
Capacity (1643–g)	15.0	50.0	125.0	175.0	160.0
Total projected costs	167.3	516.0	742.4	670.0	280.1

Note: The costs of this bill fall within budget function 550.

6. Basis for estimate: Outlays are based on specific program spend-out rates provided by HEW and updated by CBO. It was assumed that authorization levels, which are as stated in the bill, will be fully appropriated at the beginning of each fiscal year.

The provisions and amendments covering the loan and loan guarantee program (1622) are estimated to create no additional Federal costs. No loan guarantees or interest subsidies have been made by the program since fiscal year 1976 or does the administration expect the program to renew its activities. Though the bill also makes a number of technical amendments to titles XV and XVI, they are estimated to create no additional Federal costs.

7. Estimate comparison: None.
8. Previous CBO estimate: None.
9. Estimate prepared by: John Nelson.
10. Estimate approved by:

James L. Blum,
Assistant Director, for Budget Analysis.

VIII. Regulatory Impact Statement

Pursuant to section 602 of Senate resolution 4 the following is an evaluation of the anticipated regulatory impact of S. 2410.

TITLE I—REVISION AND EXTENSION OF NATIONAL HEALTH PLANNING AND DEVELOPMENT AUTHORITY

Title I revises and extends for 3 years title XV of the PHS Act, which provided for the establishment and support of a two-tiered structure of State health planning and development agencies (SHPDA's) and local health systems agencies (HSA's). While a number of amendments in title I would affect the structure, governance, staffing, and functioning of these health planning agencies, the regulatory impact of the amendments in title I is expected to be minor with the exception of the following provisions:

1. Section 109 would exempt personnel records from the requirement that HSA's and SHPDA's make their records available to the public and would permit closed meetings of the planning agencies when personnel matters are being discussed. This provision would afford protection against invasion of the personal privacy of the staff and agents of the health planning agencies.

2. The certificate of need (C/N) amendments contained in section 141 would provide that review be extended to cover expensive equipment regardless of location, and would include diagnostic equipment and therapeutic equipment costing more than $150,000. This broadening of the certificate-of-need review requirements would mean that physicians' offices and the equipment in health care facilities with annual operating costs of $50,000 or more would be subject to regulation as a result of this legislation. While individuals or institutions would experience some additional paperwork associated with applying for C/N's for major medical equipment under the new provision, the overall economic impact on such individuals and institutions of these legislative changes is expected to be minimal.

Regulations to be promulgated as a result of the provisions in title I would be in the nature of modifying or clarifying existing regulations. Because of the minor nature of the amendments it is expected that the potential additional paperwork burden will be minor.

TITLE II—REVISION AND EXTENSION OF HEALTH RESOURCES DEVELOPMENT AUTHORITY

Title II of S. 2410 extends and provides authorizations for facilities construction and other resource development activities under title XVI of the PHS Act. It also adds a new Program To Assist and Encourage the Voluntary Discontinuance of Unneeded Hospital Services (part G).

This new program would:

1. Authorize debt and incentive payments to hospitals for the discontinuance of all inpatient health services. The debt payment would be a sum consisting of the lesser of (a) total outstanding debt, or (b) unexpected depreciation (less fair market value); plus any other debt expenses. The incentive payment would include an amount to cover the planning and development of ambulatory, home health, or long-term-care services, plus the reasonable costs of termination pay or retraining for personnel.

2. Authorize incentive payments for the discontinuance of an identifiable unit that provides inpatient health services which would equal 30 percent of the charges reported as attributable to that unit in the previous fiscal year.

3. Authorize conversion payments equal to 50 percent of the reasonable costs for the conversion of an identifiable part of the hospital into providing ambulatory or long-term-care services.

4. Provide that 10 percent of the incentive payment to a hospital for closing or converting inpatient services be made available to the local health systems agency (HSA) for the purpose of assisting ambulatory care or other projects or programs within the community served by the hospital.

5. Require the HSA to determine the need for the termination/conversion and make a recommendation to the State health planning and development agency (SHPDA), which in turn makes a recommendation to the Secretary. The Secretary cannot approve an application which the SHPDA has recommended against.

6. Direct the Secretary to make a study of the first 25 applications approved under this section of the draft bill as to their effect on the elimination of unneeded hospital services, and to report the results of the study to Congress, along with his recommendations for improving the program.

A. Estimated number of individuals and businesses regulated by group or class.—The new program authorized by part G of title II could potentially affect the 7,000 non-Federal hospitals in the United States. All would be eligible under this voluntary program, but participation is in no way mandated. And it is not anticipated that more than a small fraction of the 7,000 eligible hospitals would seek such funding during the 3-year authorization period.

B. Economic impact on individuals and businesses.—There could be a positive or favorable economic impact on hospitals desiring to close or convert inpatient services (or acute care beds) to other less intensive uses, especially those presently in serious financial straits and a poor competive position because of cash flow and other problems resulting from low occupancy rates. Certainly the overall economic pact would be favorable since it is estimated that there would be an annual savings of $30,000 for each unneeded bed closed down by this program.

Provision would be made to mitigate the possible adverse effects on individual hospital employees whose jobs might be eliminated as a result. Part G provides that incentive payments to hospitals for such closure and conversion actions, would include funds to cover the costs of severance pay to and possible retraining of employees so affected.

C. Impact on personal privacy of individuals.—This new program would have no effect or impact on the personal privacy of individuals.

D. Additional paperwork, time, and costs.—While the regulations that would be promulgated to govern the closure and conversion program, would require some paperwork, time, and costs for those hospitals voluntarily applying for incentive grants, they would be relatively small or minor, especially in comparison with the burdens associated with continuing to operate inefficient, unneeded, or uneconomical facilities.

Part G directs the Secretary to conduct a study of the first 25 applications approved under this program, and report those findings and his recommendations for improving it to the Congress.

IX. Tabulation of Votes Cast in Committee

Pursuant to section 133(b) of the Legislative Reorganization Act of 1949, as amended, the following is a tabulation of votes in committee:

Motion by Senator Hatch to delete the provision requiring State certificate-of-need laws to include equipment costing over $150,00 that is to be located in physician's offices. The motion was defeated as follows:

YEAS	NAYS
Hatch	Williams
Hayakawa	Randolph
	Pell
	Kennedy
	Nelson
	Eagleton
	Cranston
	Hathaway
	Riegle
	Davits
	Schweiker
	Stafford
	Chafee

Motion by Senator Kennedy to order the bill favorably reported to the Senate, as amended, carried as follows:

YEAS	NAYS
William	
Randolph	
Pell	
Kennedy	
Nelson	
Eagleton	
Cranston	
Hathaway	
Riegle	
Javits	
Schweiker	
Stafford	
Chafee	
Hatch	
Hayakawa	

X. Section-by-Section Analysis

S. 2410 amends titles XV and XVI of the Public Heath Service Act to revise and extend the authorities and requirements under those titles for health planning and health resources development.

Section 1. Provides that the bill may be cited as the Health Planning Amendments of 1978, and that references in this act to amendment or repeal of a section or other provision will refer to a section or other provision of the Public Health Service Act.

TITLE I—REVISION AND EXTENSION OF NATIONAL HEALTH PLANNING AND DEVELOPMENT AUTHORITY

National Council on Health Planning and Development

Section 101(a). Amends section 1503(b)(1) to expand the membership of the Council from 15 to 18 members, to include as an ex officio member of the Council the Assistant Secretary for Rural Development of the Department of Agriculture, and to provide that at least 7 Council members will be consumers, including members of urban and rural medical underserved populations.

Section 101(b). Amends section 1511(a) to permit the Governor of any State involved in an interstate health systems agency to request redesignation of an interstate health service area made up of an entire standard metropolitan statistical areas (SMSA). Present law requires that all Governors involved must agree to split the SMSA if it is to be split. The Secretary of HEW retains the final authority.

Section 101(c). Amends section 1501(b)(1) to insure that the National Guidelines for Health Planning include standards for supply, distribution, and organization of health resources that reflect the unique circumstances and needs of medical underserved populations including rural communities.

Redesignation of Health Service Area Boundaries

Section 102. Amends section 1511(b)(4) to direct the Secretary to review on his own initiative, or at the request of any Governor or health systems agency, the boundaries of health service areas and to redesignate those boundaries if he finds that they no longer meet the requirements of section 1511(a) or if the boundaries for a revised health service area meet the requirements of section 1511(a) in a significantly more appropriate manner in terms of the efficiency and effectiveness of health planning efforts. Provides that when the Secretary acts on his own initiative, he is to consult with the Governor of the appropriate State or States, the chief executive officer or agency of the political subdivisions affected by the revision, the appropriate health systems agency and Statewide Health Coordinating Council. Requires similar consultation among affected parties when the boundary redesignation request originates with a Governor or HSA and further stipulates that in such cases, the request include comments on the proposed revision made by such affected individuals and entities. No proposed revision of the boundaries of a health service area shall comprise an entire State without the prior consent of the Governor. Before making any change, the Secretary is required to give notice and an opportunity for a hearing on the record by all interested persons and must make a written determination of his findings and decision. Fur-

ther requires that the Secretary, by January 1, 1979, establish by regulation criteria for revision of health service area boundaries.

Section 103. Repeals section 1511(c) which gives priority for designation of health service areas which formerly had an areawide Comprehensive Health Planning Agency under previous health planning authority.

Conflict of Interest

Section 104(a). Amends section 1512(b) to expand and clarify conflict of interest provisions for HSA members and staff. Direct HSA's to adopt procedures (in accordance with regulations of the Secretary) to insure that no member, employee, consultant, or agent participate in any matter regarding any persons, institutions, organizations, or other entity with which such individual has or has had within the past three years any substantial direct or indirect employment, fiduciary, competitive, medical staff, ownership, or other financial interest.

Section 104(b). Amends section 1524(b) to provide conflict of interest provisions for SHCC members and staff on same basis as that set forth above for HSA's.

HSA Staff

Section 105(a). Amends section 1512(b)(2)(A) to add requirements for HSA staff to assure expertise in financial and economic analysis, public health and disease prevention, mental health planning and development, and use of mental health resources. Further provides that HSA's must have staff meeting these and other existing requirements to the extent practicable.

Section 105(b). Amends section 1512(b)(2)(A) by expanding the requirements that the functions of planning and of development of health resources include mental health resources.

Section 105(c). Amends section 1512(b)(2)(A) to add a new requirement that at least one HSA staff member be assigned responsibility for providing the consumer members of the HSA governing body with such assistance as they may require to effectively perform their functions.

Selection Process for HSA Members

Section 106. Amends section 1512(b)(3) to set forth the broad outlines for the process to be used by the HSA in selecting members of its governing body and subarea councils. The selection process that assure that members are selected in accordance with the requirements of subparagraph (C) pertaining to composition of the governing body, that there is opportunity for broad participation by residents of the health service area and that such participation will be encouraged and facilitated, and that HSA members do not select other members of the HSA. The selection process is to be made public and reported to the Secretary.

Responsibilities of Public HSA's

Section 107(a). Amends section 1512(b)(3)(A) to provide that an HSA that is a public regional planning body or unit of general local government not be required to delegate to a separate governing body for health planning the exclusive authority to appoint and with cause remove members of the governing body for health planning or estab-

lish personnel rules and practices for staff or approve the agency's budget or any combination of those activities.

Public Officials on HSA's

Section 107(b). Amends section 1512(b)(3)(C)(iii)(I) to revise requirement that HSA's include public elected officials and other representatives of governmental authorities by providing that HSA's must include public elected officials and other representatives of units of general purpose government. In the latter case, individuals would have to be appointed by a unit of general purpose government or a combination thereof.

Reimbursement of HSA Members for Expenses

Section 108. Amends section 1512(b)(3)(B)(vi) to allow HSA's when appropriate to make advances to HSA members for their reasonable costs incurred in attending meetings and performing any other duties and functions of the health systems agency.

Confidential Meetings and Records Pertaining to Personnel Issues

Section 109(a). Amends section 1512(b)(3)(B)(viii) to exclude from the open meeting requirement meetings or portions thereof called to discuss the performance or remunerations of an HSA employee which, if public, would constitute a clearly unwarranted invasion of the personal privacy of such individual. Extends similar scope of protection to HSA personnel records and data.

Section 109(b). Amends section 1512(b)(6)(A) to restrict the Secretary's access to HSA personnel records and data the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Section 109(c). Amends section 1522(b)(6) to extend to employees of the State health planning and development agency the same kind of protection afforded HSA employees under section 109(a) above.

Section 109(d). Amends section 1532(b)(10) to provide that procedures and criteria for reviews of proposed health system changes restrict public access to HSA and State agency personnel records and data.

HSA Governing Body Composition

Section 110. Amends section 1512(b)(3)(C)(i) to remove the stipulation that consumers on HSA boards cannot have been providers of health care within the 12 months preceding appointment. Also clarifies that major purchasers of health care include but are not limited to unions and corporations.

Section 111(a). Amends section 1512(b)(3)(C)(ii) to permit HSA participation by providers whose principal place of business is within the respective health service area, although their residence may be elsewhere.

Section 111(b). Amends section 1512(b)(3)(C) to clarify that providers or consumers of health care also include providers or consumers of mental health care.

Section 112(a). Amends section 1512(b)(3)(C)(ii)to clarify that the term physician includes both doctors of medicine and osteopathy.

Section 112(b). Amends section 1531(3)(A) to clarify that the term physician includes both doctors of medicine and osteopathy.

Section 112(c). Amends section 1531(3) to redefine provider of health care to include provider of health or mental health care.

Section 113. Amends sections 1512(b)(3)(C)(ii) to broaden the provider of health care definition pertaining to HSA governing body composition by adding two additional provider categories for "nonprofessional health workers" and "other providers of health and mental health care."

Section 114(a). Amends section 1512(b)(3)(C)(iii)(II) to provide flexibility (but not mandate) for increased nonmetropolitan representation on HSA boards by assuring that the percentage of representatives from nonmetropolitan areas is "at least" equal to the percentage of residents in such nonmetropolitan areas.

Section 114(b). Amends section 1512(b)(3)(C)(iii)(III) to clarify that "ex officio" means nonvoting.

Section 115. Amends section 1512(b)(3)(C)(iv) to mandate that subcommittees or advisory groups of HSA boards have a consumer majority.

Liability Suits

Section 116(a). Amends section 1512(b)(4) to revise and broaden scope of protection against personal liability suits and to provide protection for consultants and agents of the HSA, as well as members and employees. Provides that no such individual will be considered liable if he could have reasonably believed he was acting within the scope of official duties and acted without gross negligence or malice toward any person affected by it.

Section 116(b). Amends section 1524 to provide protection against personal liability suits for SHCC members, employees, consultants, and agents identical to that provided under section 116(a) above to HSA's.

Requirements for Executive Committees

Section 117. Amends section 1512(b)(6) to add requirements that any executive committee of the HSA or any other entity appointed by the governing body or executive committee of the HSA and any subarea council shall conduct its business meetings in public (except for meeting or portions thereof called to discuss the performance or remuneration of an individual employee which, if public would constitute a clearly unwarranted invasion of the personal privacy of such employee), give adequate notices of its meetings to those persons who have requested such notice, and make its records and data available, upon request, to the public (other than personnel records and data regarding an individual employee the disclosure of which would constitute a clearly unwarranted invasion of the personal privacy of such employee).

Requirements for Health Plans of HSA's and State Agencies

Section 118(a). Amends section 1513(b)(2) to increase the material to be included in the health systems plan (HSP) of an HSA. In addition to other requirements, the HSP must include a description of institutional health services needed for the well-being of persons receiving care within the health service area, including at a minimum, the number and type of medical facilities, rehabilitation facilities, nursing homes, beds and equipment needed to provide acute inpatient,

psychiatric inpatient, obstetrical inpatient, neonatal inpatient, long term care, and treatment for alcohol and drug abuse, and the extent to which existing medical facilities, rehabilitation facilities, nursing homes, beds, and equipment are in need of modernization or conversion to new uses, and the extent to which new facilities and equipment need to be constructed or acquired. Similar information would have to be provided on other noninstitutional health services, specifically the number and type of health maintenance organizations, outpatient (including primary care) facilities, rehabilitation facilities, facilities for treatment of alcohol and drug abuse, and other medical facilities, and home health agencies and equipment needed to provide public health services and outpatient care.

Section 118(b). Amends section 1523(a)(4)(B) to require that certificate of need decisions be consistent (except in emergency circumstances that pose a threat to public health) with the State health plan.

Section 118(c). Amends section 1524(c)(2)(A) to require that the State health plan prepared by the SHCC have the concurrence of the Governor.

Section 118(d). Amends section 1524(c)(2) to require that the State health plan contain information similar to that set forth above for the plans developed by HSA's. Stipulates that the State health plan must be coordinated with the State mental health plan developed pursuant to the Community Mental Health Centers Act, the State alcohol abuse plan developed pursuant to the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act, and the State drug abuse plan developed pursuant to the Drug Abuse Office and Treatment Act of 1972. The State health plan is also to address the resource requirements of manpower, facilities, equipment, and funds necessary to provide access, availability, and quality services at reasonable cost to persons receiving care within the State, including at a minimum, the types of facilities and services enumerated above the HSA's.

Section 118(e). Amends section 1524(c)(2) to stipulate that until a State health plan is in effect, the Secretary may not make any grant to the State health planning and development agency pursuant to section 1525.

Section 119(a). Amends section 1513(b)(2) to expand the public hearing requireemnt of HSA's for amending as well as establishing the health systems plan.

Section 119(b). Amends section 1513(b)(3) to extend the public hearing requirement to the establishment, review, and amendment of the annual implementation plan, as well as the HSP.

Section 119(c). Amends section 1513(b)(2) to require that the HSP include identifiable alcohol abuse, drug abuse, and mental health components, and address specifically the needs of all medical underserved populations in the health service area.

Technical assistance

Section 120. Amends section 1513(c)(2) to mandate HSA's to provide technical assistance in obtaining and filling out necessary forms to applicants applying for projects needed to achieve the HSP. Permits HSA's to also provide other technical assistance.

Carryover of grant funds

Section 121(a)–(d). Amends sections 1513(c)(3), 1516(a), 1525(a), and 1526(c)(1) to allow for carryover of grant funds for HSA's and State agencies and for area health services development funds and State rate regulation projects. Provides that in the event a grant is renewed, it may be carried foward to the subsequent grant period without being deducted from the subsequent grant award.

Coordination HSA/State agency activities

Section 122(a). Amends section 1513(d) to provide that an HSA will also coordinate its activities with entities which review rates and budgets of health care facilities in the health service area and with appropriate area agencies on aging, local and regional alcohol abuse, drug abuse, and mental health planning agencies.

Section 122(b). Amends section 1522(b)(7)(A) to provide that the State agency coordinate its activities with such rate and budget review entities in the State.

Appropriations review

Section 123(a). Amends section 1513(g) to clarify that HSA appropriateness review should, at a minimum, address the issues of accessibility, financial viability, cost effectiveness, costs and charges to the public and quality of services provided.

Section 123(b). Amends section 1513(e)(1)(B) to clarify that grants or contracts under titles IV, VII, or VIII of the PHS Act should not be reviewed by the HSA's unless they are to be made, entered into, or used to support the development of health resources or the delivery of health services that would make a significant change in the health services offered within the health service area.

Section 124. Amends section 1513(g)(1) to focus but not limit the scope of mandated HSA appropriateness review to at least those services included in the State health plan.

Technical assistance

Section 125. Amends section 1514 to require the Secretary to provide technical assistance to agencies that have the potential to become HSA's as defined in the law.

Section 126(a)–(b). Deletes the last sentence of section 1515(b) and the last sentence of section 1515(c)(2) in order to eliminate the priority for HSA designation of former 314(b) agencies and regional medical programs formerly authorized under title IX.

Extension of full designation periods for HSA's

Section 127(a)–(b). Amends sections 1515(c)(1) and 1515(c)(3) to extend the period of full designation agreements of HSA's from 1 year to 3 years, and to permit the Secretary, if he finds an HSA has not been performing satisfactorily, to terminate it or return it to a conditional status for 1 year, after which time the agency must either be automatically terminated or returned to full designation.

Section 128. Amends section 1515(d) to provide a conforming amendment pertaining to HSA designation agreements.

HSA funding levels

Section 129(a)–(b). Amends sections 1516(b)(2)(A)(i) and 1516(b)(3) to provide that minimally funded HSA's shall receive at

least $250,000 in the fiscal year ending September 30, 1979, $270,000 in fiscal year 1980, and $290,000 in any succeeding fiscal year.

Section 129(c). Amends section 1516(c)(1) to authorize appropriations of $150 million for fiscal year 1979, $175 million for fiscal year 1980, and $200 million for fiscal year 1981.

Section 129(d). Amends section 1516(d) to provide that, of the amounts appropriated under section 129(c), the Secretary may use not more than 5 percent of such amounts to increase grants in such fiscal year to a health systems agency to assist it in meeting extraordinary expenses including but not limited to those that may occur when HSA's are located in more than one State or serve a large health service area or a large rural or urban medical underserved population.

Section 129(e). Amends section 1516(c)(2) to conform with sections 129 (a) and (b).

Extension of full designation periods for State agencies

Section 130(a)–(b). Amends setcion 1521(b)(3) and 1521(b)(4) to change designation requirements for the State agencies from annually to every 3 years and to permit the Secretary the option of either terminating or returning a fully designated SHPDA to conditional status for a 1-year period for nonperformance of its functions. After the 1-year period, the Secretary must either fully designate the SHPDA or terminate its agreement.

Penalty for States not in compliance

Section 131. Amends section 1521(d) to provide that a State without a State agency designation agreement in effect by September 30, 1980, would be subject to a 25-percent reduction in the amount of any allotment, grant, loan, loan guarantee, and any contract under this act, the Community Mental Health Centers Act, or the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 for the development, expansion, or support of health resources until such time as an agreement is in effect. Such amounts would be reduced by 50 percent if no agreement were in effect by September 30, 1981, by 75 percent after September 30, 1982, and by 100 percent after September 30, 1983.

Judicial review of State agency decisions

Section 132(a). Amends section 1522(b) to provide for judicial review of a final decision rendered by a State agency under a certificate of need or appropriateness review. Any person adversely affected by such a decision may within a reasonable period of time after the decision is made and any review is made by the State reviewing agency (other than the SHPDA) designated by the Governor, obtain judicial review of such a decision in an appropriate State court. The State agency decision is to be affirmed unless it is found to be arbitrary or capricious, or was not made in conformity with the applicable law.

Section 132(b). Amends section 1522(b)(13)(A) to require that appeals of State agency decisions be performed in a timely manner.

Section 133. Amends section 1522(c) to effect a conforming change proposed under section 130 changing annual designation of the SHPDA to triannual.

Technical assistance

Section 134(a). Amends section 1523(a) to require SHPDA's to provide technical assistance in obtaining and filling out the necessary forms to individuals and public and private entities for the development of projects and programs.

State health plan

Section 134(b). Amends section 1523(a)(2) to require that the preliminary State health plan include an identifiable alcohol abuse, drug abuse, and mental health component to be prepared by the respective alcoholism, drug abuse, and mental health authorities, respectively, designated by the Governor. The alcohol abuse, drug abuse, and mental health components of the HSP's submitted by HSA's for inclusion in the State health plan may, as found necessary by the respective State authorities, contain revisions of such components to achieve their appropriate coordination or to deal more effectively with statewide alcohol abuse, drug abuse, and mental health needs. The remainder of such preliminary State plan may, as found necessary by the State agency, also contain revisions of such HSP's to achieve their appropriate coordination or to deal more effectively with statewide needs. The preliminary State health plan will be submitted to the SHCC for approval or disapproval and for use in developing the final State health plan.

Certificate of need

Section 135. Amends section 1523(a)(4) to clarify the Secretary's role in approving certificate of need programs by revising the current provision calling for a program satisfactory to the Secretary and substituting a requirement that the program be consistent with standards established by regulations of the Secretary. Requires the certificate-of-need program to provide enforcement procedures and penalties. Further requires the program to conduct a periodic review at least every 24 months of the progress being made by an institution granted a certificate of need. Requires a certificate of need to be withdrawn if (in the absence of unforeseen and unavoidable circumstances) substantial progress is not being made toward making the service or facility for which the certificate was issued available for use. Also requires that issuance of a certificate of need be based solely on the record established in administrative and judicial proceedings (as provided for in this title) held with respect to an application. Provides that no certificate-of-need program shall have provisions for the review and determination of need of the services, facilities, equipment, and organization of health maintenance organizations that are in addition to provisions for the review and determination of need of the services, facilities, equipment, and organization of other providers of ambulatory health care.

Section 136. Amends section 1523(a)(5) to provide a technical and conforming amendment which clarifies the role of the HSA in States with approved certificate-of-need programs. Would, in effect, delete requirements of section 1523(a)(5) once there is an acceptable certificate of need program in place.

Statewide Health Coordinating Council (SHCC)

Section 137(a)–(b). Amends sections 1524(c)(1) and 1513(b)(2) to direct the SHCC to establish in consultation with the HSA's and the State agency a uniform format for HSP's and AIP's.

Section 137(c). Amends section 1524(b)(1) to clarify that consumers and providers of health care include consumers and providers of mental health care, for purposes of SHCC composition. Further amends section 1524(b)(1)(D) to provide, for ex officio representation of the Veterans' Administration on the SHCC when the State has at least one VA facility, rather than at least two such facilities as currently provided.

Section 137(d). Amends section 1524(c)(6) to mandate that the SHCC review State plans pursuant to section 409 and 410 of the Drug Abuse Office and Treatment Act.

Section 137(e). Amends section 1524(b)(1) to require that the SHCC include consumer members who are members of rural and urban medically underserved populations, if such populations exist in the State.

Authorization levels for State agencies

Section 138. Amends section 1525(c) to increase authorization levels for grants to State health planning and development agencies. Authorizes $40 million for fiscal year 1979, $45 million for fiscal year 1980, and $50 million for fiscal year 1981.

Section 139. Amends section 1526(e) to extend authorizations for grants for State rate regulation experiments as follows: $6 million for fiscal year 1979, $7 million for fiscal year 1980, and $7 million for fiscal year 1981.

Definitions

Section 140(a). Amends section 1531(3)(A) by striking "substance" and inserting in lieu thereof "alcohol and drug" and by including rehabilitation facilities among the institutions included in the "provider of health care" definition.

Section 140(b). Amends section 1531(3)(B)(i) to allow consumers who serve on governing boards of other health organizations and agencies to be considered as consumers, rather than indirect providers, for the purposes of this act.

Section 141. Amends section 1531(5) to broaden State certificate-of-need requirements by redefining "institutional health services" to mean health services provided through health care facilities (excluding facilities of health maintenance organizations other than hospitals) as defined in regulations of the Secretary, including but not limited to private and public hospitals, rehabilitation facilities, and nursing homes if such services entail annual operating costs of $50,000 or more; and diagnostic or therapeutic equipment, acquired through purchase, rental, lease, or gift, valued at the time of acquisition in excess of $150,000, used in the delivery of health care services by any person, institution, or other entity. In determining whether diagnostic or therapeutic equipment has a value in excess of $150,000, the value of studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition of such equipment will be included.

Procedures and criteria for review

Section 142. Amends section 1532(a) to stipulate that procedures and criteria for review by HSA's and State agencies must provide that applications be submitted in accordance with established timetables, that reviews be undertaken in a timely fashion, and that applications for similar types of services and facilities be considered in relation to each other no less often than twice a year. Reviews of similar types of institutional health services affecting the same service area must be considered in relation to each other. This section also provides that HSA's and State agencies must cooperate in the development of procedures and criteria to the extent appropriate to the achievement of efficiency in their reviews and consistency in criteria for such reviews.

Section 143. Amends section 1532(b) to provide that for HSA and State agency reviews of certificate of need applications and reviews of appropriateness of services, and where appropriate for other reviews, each participant may present evidence and arguments orally and/or by written submission; each participant may cross-examine any other participant who makes a factual allegation relevant to such review; a hearing record is to be maintained; HSA and State agency decisions are to be based solely on the hearing record; and there will be a prohibition on ex parte contracts with individuals voting on the review process.

Section 144. Amends section 1532(b)(1) to require timely written notification to all affected parties at the beginning of a review and to require that all persons who have asked to be placed on a mailing list maintained by the HSA or SHPDA be notified of certain reviews by such agencies.

Section 145. Amends section 1532(b)(7) to provide for a timely notification of providers of health services and other persons of certain information.

Section 146. Amends section 1532(b)(8) to specify that public hearings are to be held prior to any decision made in the course of HSA or State agency review if requested by persons directly affected by the review.

Section 147(a). Amends section 1532(c)(9)(B) to provide that in the case of a construction project, HSA and State agency review will consider the probable impact of the project on the costs and charges of providing health services not only by the person proposing such construction project (as currently provided) but also "on the costs of providing health services by other persons."

Section 147(b). Amends section 1532(c) to provide that in addition to existing criteria the HSA and State agency must consider, in the case of existing services or facilities, the quality of care provided by such services or facilities in the past and the extent to which such proposed services will be accessible to all the residents of the area to be served by such services.

Section 147(c). Amends section 1532 to establish criteria under which the certificate of need applications of HMO's will be reviewed and approved. Applications of HMO's for new institutional health services must be approved by the State agency if it finds (in accordance with criteria prescribed by the Secretary) that approval is re-

quired to meet the needs of present HMO members and new members who can reasonably be expected to enroll, and if the HMO is unable to provide, through services or facilties which can reasonably be expected to be available to the organization, its institutional health services in a reasonable and cost-effective manner consistent with the basic method of operation of the HMO and which makes such services available on a long-term basis through physcians and other health professionals associated with it.

Centers for health planning.

Section 148(a)–(b). Amends section 1534(a) and 1534(b)(1) to require the Secretary to enter into grants with the Centers for Health Planning, rather than allowing the existing option of grants or contracts.

Section 148(c). Amends section 1534(c)(2) to require the types of assistance and dissemination of information to HSA's and State agencies explicitly set forth in subsections (a) and (c) of section 1534 in order to be eligible for grants from the Secretary. Adds a requirement that Centers develop and disseminate methodologies to educate new HSA board members and staff and continuing education for present HSA members and staff and State agency staff.

Section 148(d). Amends section 1534(d) to extend the authorization for the Centers for Health Planning as follows: $12 million for fiscal year 1979, $15 million for fiscal year 1980, and $18 million for fiscal year 1981.

Comment authority

Section 149. Amends section 1535 to broaden the comment authority to any interested party. This would pertain to the process undertaken by the Secretary to review in detail at least every 3 years the structure, operation, and performance of each HSA and SHPDA. The Secretary is directed to consider the comments of any interested person.

Section 150. Amends section 1536(b)(3) to clarify the functions of the State Agencies in States eligible for section 1536 status. Provides that the Stae agency shall perform (rather than may perform), in addition to the functions prescribed by section 1523, the functions prescribed by section 1513 and be eligible to receive grants authorized by sections 1516 and 1640, provided that nothing shall prevent the State Agency from contracting with an HSA for performance of a part of such functions or participation in the performance of such functions.

Coordination with mental health activities

Section 151(a)–(b). Amends section 2(a)(3)(B) of Public Law 93–641 and section 1502 in order to insure more effective coordination of the planning efforts at the local and State level between the planning entities designated under the Community Mental Health Centers Act and the Health Planning and Resources Development Act of 1974 and to insure the more effective coordination of health and mental health services. Adds a Congressional finding that lack of effective coordination between the mental health care system and the physical health care system, both by providers and planners, has promoted fragmentation, lack of continuity, and inappropriate utili-

zation of health resources. Further notes the lack of attention to and emphasis on the behavioral aspects of physical health care and status. Adds to the list of national health priorities the following:

Promotion of those health services which are provided in a manner cognizant of the emotional and psychological components of the prevention and treatment of illness and the maintenance of health;

The elimination of inappropriate placement in institutions of persons with mental health problems and improvements in the quality of care provided to persons with mental health problems for whom institutional care is appropriate; and

The assurance of access to community mental health centers and other mental health care providers for needed mental health services and the emphasis on outpatient care as a less restrictive alternative to inpatient mental health services.

Indian self-determination

Section 152(a). Amends section 1513(e) to provide for Indian self-determination as related to health planning by inserting after the term "Indian tribe" the phrase "(as defined in section 4(b) of the Indian Self-Determination and Education Assistance Act)."

Review of Federal funds

Section 152(b). Amends 1513(e) to require that when an HSA is requested to review a proposed use of Federal funds, other than those specified in section 1513(e)(1)(A), to support the development of institutional health services intended for use in the health service area, the health systems agency must, within 60 days of receiving such a request, submit its views on such proposed use to the Federal department or agency involved and to the appropriate committees of Congress.

Indian self-determination

Section 152(c). Amends section 1513(e) to add a new requirement for HSA's having an Indian tribe or intertribal Indian organization located within such agencies health service areas. HSA's are directed to carry out their functions in a manner that recognizes tribal self-determination and are to seek to enter into agreements with the tribes or organizations on matters of mutual concern, as defined in regulations of the Secretary.

Definitions of health maintenance organization, medical underserved population, and rehabilitation facility

Section 153. Amends section 1531 to add a new definition of the term "health maintenance organization" for purposes of this act. The term "health maintenance organization" means an entity which has an approved application for assistance under section 1304, or a public or private organization, organized under State laws, which (1) provides or otherwise makes available to enrolled participants health care services, including at least the following basic health care services: usual physician services, hospitalization, laboratory, X-ray, emergency and preventive service, and out-of-area coverage; (2) is compensated (except for copayment) for the provision of the basic health care services listed in paragraph (1) to enrolled participants on a pre-

27-409 O - 78 - 7

determined periodic rate basis; and (3) provides physicians services primarily (i) directly through physicians who are either employees or partners of such organization, or (ii) through arrangements with individual physicians or one or more groups of physicians (organized on a group practice or individual practice basis). Provides that for purposes of section 1532(d), as added by section 147(c) above, a health maintenance organization means an entity determined by the Secretary to be a qualified health maintenance organization pursuant to section 1310(d) of the PHS Act.

Further provides that the term "medical underserved population" has the same meaning as such term has under section 330(b)(3) of the PHS Act.

Defines the term "rehabilitation facility" as follows: a facility operated for the primary purpose of providing rehabilitation services to handicapped individuals and providing singly or in combination one or more of the following services for handicapped individuals: (A) rehabilitation services which shall include, under one management, medical, psychological, social, and vocational services, (B) testing, fitting, or training in the use of prosthetic and orthotic devices, (C) prevocational conditioning or recreational therapy, (D) physical and occuptional therapy, (E) speech and hearing therapy, (F) psychological and social services, (G) evaluation of rehabilitation potenial, (H) personal and work adjustment, (I) vocational training with a view toward career advancement (in combination with other rehabiltation services), (J) evaluation or control of specific disabilities, (K) orientation and mobility services to the blind, and (L) extended employment for those handicapped individuals who cannot be readily absorbed in the competitive labor market, except that all medical and related health services must be described by, or under the formal supervision of, persons licensed to prescribe or supervise the provision of such services in the State.

Effective dates

Section 154. Provides that amendments made by this title will take effect on the date of enactment of this Act, except for the following: amendments made by section 104, 105(a), 105(b), 106, 107, 113, 114(a), 118, 119(c), 134(b), 135, 137(a), 137(b), 137(c), and 148(a) will take effect one year after the date of enactment and the amendments made by sections 142 and 147 take effect six months after enactment, except that on or that the date of enactment of this Act health systems agencies, State agencies, and SHCCs may make the organizational and related changes required and may act in accordance with the changes in their functions made by such amdenments.

TITLE II—REVISION AND EXTENSION OF HEALTH RESOURCES DEVELOPMENT AUTHORITY

State medical facilities plan

Section 201. Amends section 1603(3) to require that the Governor as well as the SHCC approve the State medical facilities plan.

Authorization levels

Section 202. Amends section 1613 to authorize appropriations for allotments to States under section 1610 as follows: $135 million for

fiscal year 1979, fiscal year 1980, and fiscal year 1981. Further provides that the Secretary may make funds appropriated for use in fiscal year 1976 under this section but not expended available through September 30, 1979, to carry out the purposes of section 1625(d) pertaining to special project grants for public hospitals with safety hazards or accreditation problems.

Section 203. Amends section 1622(e)(2) to authorize for appropriations such sums as may be necessary for fiscal year 1979, fiscal year 1980, and fiscal year 1981 for loans and loan guarantees.

Section 204. Amends section 1625(d) to authorize appropriations for grants for construction or modernization projects under section 1625 as follows: $75 million for fiscal year 1979, $100 million for fiscal year 1980, and $125 million for fiscal year 1981.

Section 205. Amends section 1640(d) to authorize appropriations for grants for area health services development funds under section 1640(a) as follows: $120 million for fiscal year 1979, $150 million for fiscal year 1980, and $180 million for fiscal year 1981.

Voluntary discontinuance of unneeded hospital services

Section 206. Amends title XVI to add at the end the following new part:

Part G—Program to Assist and Encourage the Voluntary Discontinuance of Unneeded Hospital Services

New section 1641. Provides that the Secretary will, by April 1, 1979, establish a program under which financial assistance and encouragement will be provided for the consolidation of duplicative hospital services and the discontinuance of unneeded hospital services.

Assistance under the program

New section 1642(a)(1). Permits any hospital in operation on the date of enactment of this part to apply for a debt payment and an incentive payment if it intends to discontinue providing inpatient health services, for an incentive payment if it intends to discontinue an identifiable unit of the hospital providing inpatient health services, or for a conversion payment if it intends to convert an identifiable part of the hospital into providing ambulatory care services, long-term care services, or any other services designated by the Secretary. In the case of conversion, the State agency which would have jurisdiction over such services must determine, after considering recommendations of the appropriate HSA, that such services are needed.

New section 1642(a)(2). Provides that the incentive payment authorized above may be used for (A) the planning, development (including the cost of construction and acquisition of equipment), and delivery of ambulatory care services, home health care services, long-term care services, or other services (designated by the Secretary) for the community served by the applicant for such payment, which services the State agency has determined are needed, after considering the recommendations of the appropriate HSA; (B) if the applicant has merged with another hospital, preparation of that hospital to serve patients of the closed hospital; (C) reasonable (as determined under guidelines prescribed by the Secretary) termination pay for personnel who lose employment because of discontinued inpatient services, or

for retraining of such personnel, and assisting them in securing employment; or (D) any combination of these activities.

New section 1642(b). Provides that an application of a hospital for such assistance must include the following information:

description of the service (or services) to be discontinued or the part of the hospital to be converted;

an evaluation of the impact of such change on the provision of health care in the health service area where the hospital is located;

if the services of a hospital unit or all hospital services are to be discontinued or converted, an estimate of the change in the applicant's revenues resulting from such change;

with respect to incentive payments for discontinuance of all hospital services, a description of the activities for which such payment is intended, the means with which (including any Federal financial assistance the applicant intends to apply for) and the manner in which the applicant will carry out such activities, the amount to be expended, and identification of the person (if it is not the applicant) responsible for making expenditures;

with respect to incentive payments for discontinuing identifiable hospital units, a description of the use the applicant will make of such payment;

an evaluation of the impact of such discontinuance or conversion on the employees of such hospital; and

such other information as the Secretary may by regulation require.

Provides that a hospital having an application under this subsection approved by the Secretary is entitled to receive the payments applied for.

New section 1642(c). Provides that the health systems agency for the health service area in which the applicant is located will determine the need for the service proposed to be discontinued or part of the hospital to be converted. The HSA will make a recommendation to the State agency respecting approval by the Secretary of such applicant's application. HSA determinations will be based on criteria developed pursuant to section 1532(c).

New section 1642(d). Provides that the State agency, after considering the HSA's recommendation under subsection (c) above, will make a recommendation to the Secretary regarding approval by the Secretary of such an application. A State agency recommendation will be based on the need for the service to be discontinued or part of the hospital to be converted, and other criteria the Secretary may by regulation prescribe, and will be accompanied by the HSA's recommendation with respect to approval of such application.

New section 1642(e). Directs the Secretary to consider recommendations of the State agency and HSA and prohibits him from approving an application which a State agency has recommended against.

New section 1642(f). Directs HSA's and State agencies, in considering the need for the services to be discontinued, to give special consideration to the unmet needs and existing access patterns of urban or rural poverty populations.

New section 1642(g). States that for purposes of this title, the term "hospital" means an institution (including a distinct part of an institution participating in the program established under title XVIII of the Social Security Act) which satisfies paragraph (1) and (7) of section 1861(e) of such act, but does not include a Federal hospital.

Amount of payments

New section 1643(a). Provides that the amount of a debt payment for discontinuance of all inpatient services is the sum of the lesser of (A) the total outstanding financial obligation attributable (as determined under regulation) to the acquisition of equipment and facilities of the hospital, or (B) the amount of unexpended depreciation attributable (as determined by regulation) to such equipment and facilities, less the fair market value (as defined by the Secretary) of the equipment and facilities, plus any other expenses (as defined by regulation) resulting from the financial obligation of the applicant being satisfied before due.

New section 1643(b). Provides that incentive payments to a hospital for discontinuance of all of its services would include an amount not in excess of the amount reported by the hospital under section 1642. If a hospital is discontinuing a unit, the incentive payment would equal an amount not in excess of 30 percent of the charges reported as attributable to that unit in the previous hospital accounting fiscal year pursuant to generally acceptable accounting principles prescribed by regulations of the Secretary.

New section 1643(c). Provides that conversion payments would equal 50 percent of the reasonable (as determined by criteria established in regulations) cost of the conversion approved in the application.

New section 1643(d). Provides that the debt, incentive, and conversion payment to which a hospital is entitled will be paid in a single payment.

New section 1643(e). Provides that HSA's will receive a payment equal to 10 percent of any incentive payment made for discontinuance of all or part of the services of a hospital located in the HSA's health service area. HSA's may use these payments only to make grants and contracts in accordance with section 1513(c)(3) for projects and programs within the community served by such hospital, or if such community does not need any such project or program, within another community.

New section 1643(f). Precludes the Secretary from making a payment under this section until the Secretary of Labor has certified that fair and equitable arrangements have been made to protect the interests of employees affected by the discontinuance of services against worsening of their positions with respect to their employment including, but not limited to, arrangements to preserve the rights of employees under collective-bargaining agreements; continuation of collective-bargaining rights consistent with provisions of the National Labor Relations Act; reassignment of affected employees to other jobs; retraining programs; protecting pension, health benefits, and other fringe benefits of affected employees; and arranging adequate severance pay, if necessary. Procedure for certification by the Secretary of Labor shall conform to standards established by him by regulation.

New section 1643(g). Authorizes appropriations for payments under this part in the following amount: $150 million for fiscal year 1979, $200 million for fiscal year 1980, and $250 million for fiscal year 1981.

Study

New section 1644. Directs the Secretary to make a study of the first 25 applications approved under section 1642 to determine their effect on the elimination of unneeded hospital services. The Secretary will report the results of such study to the Congress together with his recommendations for any revisions in the program which he determines to be appropriate, including any revision in the authorization of appropriations for such program.

Effective date

Section 207. Provides that, except as provided in section 206, the amendments made by this title will take effect on the date of enactment.

TITLE III—MISCELLANEOUS AMENDMENTS

Section 301. Amends section 314 of the PHS Act by repealing subsections (a), (b), and (c).

Section 302. Repeals title IX in its entirety.

Section 303. Provides that the amendments made by this title will take effect on the date of enactment of this act.

XI. Changes in Existing Law

In compliance with subsection 4 of rule XXIX of the Standing Rules of the Senate, changes in existing law made by the bill as reported are shown as follows (existing law in which no change is proposed is shown in roman; existing law proposed to be omitted is enclosed in black brackets; new matter is shown in italic):

Amendments to Public Law 93-641

FINDINGS AND PURPOSE

Sec. 2. (a) The Congress makes the following findings:

(1) The achievement of equal access to quality health care at a reasonable cost is a priority of the Federal Government.

(2) The massive infusion of Federal funds into the existing health care system has contributed to inflationary increases in the cost of health care and failed to produce an adequate supply or distribution of health resources, and consequently has not made possible equal access for everyone to such resources.

(3) The many and increasing responses to these problems by the public sector (Federal, State, and local) and the private sector have not resulted in a comprehensive, rational approach to the present—

(A) lack of uniformly effective methods of delivering health care;

(B) maldistribution of health care facilities and manpower; [and]

(C) increasing cost of health care[.]*;*

(D) lack of effective coordination between the mental health care system and physical health care system, both by providers and planners, have promoted fragmentation, lack of continuity, and inappropriate utilization of the Nation's health care resources; and

(E) lack of attention to and emphasis on the behavioral aspects of physical health care and status.

(4) Increases in the cost of health care, particularly of hospital stays, have been uncontrollable and inflationary, and there are presently inadequate incentives for the use of appropriate alternative levels of health care, and for the substitution of ambulatory and intermediate care for inpatient hospital care.

(5) Since the health care provider is one of the most important participants in any health care delivery system, health policy must address the legitimate needs and concerns of the provider if it is to achieve meaningful results; and, thus, it is imperative that the provider be encouraged to play an active role in developing health policy at all levels.

(6) Large segments of the public are lacking in basic knowledge regarding proper personal health care and methods for effective use of available health services.

(b) In recognition of the magnitude of the problems described in subsection (a) and the urgency placed on their solution, it is the purpose of this Act to facilitate the development of recommendations for a national health planning policy, to augment areawide and State planning for health services, manpower, and facilities, and to authorize financial assistance for the development of resources to further that policy.

REVISION OF HEALTH PLANNING PROGRAMS UNDER THE PUBLIC HEALTH SERVICE ACT

SEC. 3. The Public Health Service Act is amended by adding at the end the following new title:

PUBLIC HEALTH SERVICE

TITLE XV—NATIONAL HEALTH PLANNING AND DEVELOPMENT

PART A—NATIONAL GUIDELINES FOR HEALTH PLANNING

NATIONAL GUIDELINES FOR HEALTH PLANNING

SEC. 1501. (a) The Secretary shall, within eighteen months after the date of the enactment of this title, by regulation issue guidelines concerning national health planning policy and shall, as he deems appropriate, by regulation revise such guidelines. Regulations under this subsection shall be promulgated in accordance with section 553 of title 5, United States Code.

(b) The Secretary shall include in the guidelines issued under subsection (a) the following:

(1) Standards respecting the appropriate supply, distribution, and organization of health resources. *Such standards shall reflect the unique circumstances and needs of medical underserved populations including isolated rural communities.*

(2) A statement of national health planning goals developed after consideration of the priorities, set forth in section 1502, which goals, to the maximum extent practicable, shall be expressed in quantitative terms.

(c) In issuing guidelines under subsection (a) the Secretary shall consult with and solicit recommendations and comments from the health systems agencies designated under part B, the State health planning and development agencies designated under part C, the Statewide Health Coordinating Councils established under part C, associations and specialty societies representing medical and other health care providers, and the National Council on Health Planning and Development established by section 1503.

NATIONAL HEALTH PRIORITIES

SEC. 1502. The Congress finds that the following deserve priority consideration in the formulation of national health planning goals and in the development and operation of Federal, State, and area health planning and resources development programs:

(1) The provision of primary care services for medically underserved populations, especially those which are located in rural or economically depressed areas.

(2) The development of multi-institutional systems for coordination or consolidation of institutional health services (including obstetric, pediatric, emergency medical, intensive and coronary care, and radiation therapy services).

(3) The development of medical group practices (especially those whose services are appropriately coordinated or integrated with institutional health services), health maintenance organizations, and other organized systems for the provision of health care.

(4) The training and increased utilization of physician assistants, especially nurse clinicians.

(5) The development of multi-institutional arrangements for the sharing of support services necessary to all health service institutions.

(6) The promotion of activities to achieve needed improvements in the quality of health services, including needs identified by the review activities of Professional Standards Review Organizations under part B of title XI of the Social Security Act.

(7) The development by health service institutions of the capacity to provide various levels of care (including intensive care, acute general care, and extended care) on a geographically integrated basis.

(8) The promotion of activities for the prevention of disease, including studies of nutritional and environmental factors affecting health and the provision of preventive health care services.

(9) The adoption of uniform cost accounting, simplified reimbursement, and utilization reporting systems and improved management procedures for health service institutions.

(10) The development of effective methods of educating the general public concerning proper personal (including preventive) health care and methods for effective use of available health services.

(*11*) *The promotion of those health services which are provided in a manner cognizant of the emotional and psychological components of the prevention and treatment of illness ad the maintenance of health.*

(*12*) *The elimination of inappropriate placement in institutions of persons with mental health problems and improvements in the quality of care provided to persons with mental health problems for whom institutional care is appropriate.*

(*13*) *The assurance of access to community mental health centers and other mental health care providers for needed mental health services and the emphasis on outpatient care as a less restrictive alternative to inpatient mental health services.*

NATIONAL COUNCIL ON HEALTH PLANNING AND DEVELOPMENT

SEC. 1503. (a) There is established in the Department of Health, Education, and Welfare an advisory council to be known as the National Council on Health Planning and Development (hereinafter in this section referred to as the "Council"). The Council shall advise, consult with, and make recommendations to, the Secretary with respect to (1) the development of national guidelines under section 1501. (2) the implementation and administration of this title and title XVI, and (3) an evaluation of the implications of new medical technology for the organization, delivery, and equitable distribution of health care services.

(b)(1) The Council shall be composed of [fifteen] *eighteen* members. The Chief Medical Director of the Veterans' Administration, the Assistant Secretary for Health and Environment of the Department of Defense, the assistant Secretary for Rural Development of the Department of Agriculture, and the Assistant Secretary for Health, Education, and Welfare shall be nonvoting ex officio members of the Council. The remaining members shall be appointed by the Secretary and shall be persons who, as a result of their training, experience, or attainments, are exceptionally well qualified to assist in carrying out the functions of the Council. Of the voting members, [not less than five shall be persons who are not providers of health services] *not less than seven shall be persons who are not providers of health services including individuals who are members of urban and rural medical underserved populations*, and not more than three shall be officers or employees of the Federal Government, not less than three shall be members of governing bodies of health systems agencies designated under part B, and not less than three shall be members of Statewide Health Coordinating Councils established under section

1524. The two major political parties shall have equal representation among the voting members on the Council.

(2) The term of office of voting members of the Council shall be six years, except that—

(A) of the members first appointed to the Council, four shall be appointed for terms of two years and four shall be appointed for terms of four years, as designated by the Secretary at the time of appointment; and

(B) any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed only for the remainder of such term.

A member may serve after the expiration of his term until his successor has taken office.

(3) The chairman of the Council shall be selected by the voting members from among their number. The term of office of the chairman of the Council shall be the lesser of three years or the period remaining in his term of office as a member of the Council.

(c) (1) Except as provided in paragraph (2), the members of the Council shall each be entitled to receive the daily equivalent of the annual rate of basic pay in effect for grade GS–18 of the General Schedule for each day (including traveltime) during which they are engaged in the actual performance of duties vested in the Council.

(2) Members of the Council who are full-time officers or employees of the United States shall receive no additional pay on account of their service on the Council.

(3) While away from their homes or regular places of business in the performance of services for the Council, members of the Council shall be allowed travel expenses, including per diem in lieu of subsistence, in the same manner as persons employed intermittently in the Government service are allowed expenses under section 5703(b) of title 5, United States Code.

(d) The Council may appoint, fix the pay of, and prescribe the functions of such personnel as are necessary to carry out its functions. In addition, the Council may procure the services of experts and consultants as authorized by section 3109 of title 5, United States Code, but without regard to the last sentence of such section.

(e) The provisions of section 14(a) of the Federal Advisory Committee Act shall not apply with respect to the Council.

Part B—Health Systems Agencies

HEALTH SERVICE AREAS

Sec. 1511. (a) Except as provided in section 1536, there shall be established, in accordance with this section, health service areas throughout the United States with respect to which health systems agencies shall be designated under section 1515. Each health service area shall meet the following requirements:

(1) The area shall be a geographic region appropriate for the effective planning and development of health services, determined on the basis of factors including population and the availability of resources to provide all necessary health services for residents of the area.

(2) To the extent practicable, the area shall include at least one center for the provision of highly specialized health services.

(3) The area, upon its establishment, shall have a population of not less than five hundred thousand or more than three million; except that—

(A) the population of an area may be more than three million if the area includes a standard metropolitan statistical area (as determined by the Office of Management and Budget) with a population of more than three million, and

(B) the population of an area may—

(i) be less than five hundred thousand if the area comprises an entire State which has a population of less than five hundred thousand, or

(ii) be less than—

(I) five hundred thousand (but not less than two hundred thousand) in unusual circumstances (as determined by the Secretary), or

(II) two hundred thousand in highly unusual circumstances (as determined by the Secretary),

if the Governor of each State in which the area is located determines, with the approval of the Secretary, that the area meets the other requirements of this subsection.

(4) To the maximum extent feasible, the boundaries of the area shall be appropriately coordinated with the boundaries of areas designated under section 1152 of the Social Security Act for Professional Standards Review Organizations, existing regional planning areas, and State planning and administrative areas.

The boundaries of a health service area shall be established so that, in the planning and development of health services to be offered within the health service area, any economic or geographic barrier to the receipt of such services in nonmetropolitan areas is taken into account. The boundaries of health service areas shall be established so as to recognize the differences in health planning and health services development needs between nonmetropolitan and metropolitan areas. Each standard metropolitan statistical area shall be entirely within the boundaries of one health service area, except that [if the Governor of each State] *if the Governor of any State* in which a standard metropolitan statistical area is located determines, with the approval of the Secretary, that [in order to meet the other requirements of this subsection] a health service area should contain only part of the standard metropolitan statistical area, then such statistical area shall not be required to be entirely within the boundaries of such health service area.

(b)(1) Within thirty days following the date of the enactment of this title, the Secretary shall simultaneously give to the Governor of each State written notice of the initiative of proceedings to establish health service areas throughout the United States. Each notice shall contain the following:

(A) A statement of the requirement (in subsection (a)) of the establishment of health service areas throughout the United States.

(B) A statement of the criteria prescribed by subsection (a) for health service areas and the procedures prescribed by this subsection for the designation of health service area boundaries.

(C) A request that the Governor receiving the notice (i) designate the boundaries of health service areas within his State, and, where appropriate and in cooperation with the Governors of adjoining States, designate the boundaries within his State of health service areas located both in his State and in adjoining States, and (ii) submit (in such form and manner as the Secretary shall specify) to the Secretary, within one hundred and twenty days of the date of enactment of this title, such boundary designations together with comments, submitted by the entities referred to in paragraph (2), with respect to such designations.

At the time such notice is given under this paragraph to each Governor, the Secretary shall publish as a notice in the Federal Register a statement of the giving of his notice to the Governor and the criteria and procedures contained in such notice.

(2) Each State's Governor shall in the development of boundaries for health service areas consult with and solicit the views of the chief executive officer or agency of the political subdivisions within the State, the State agency which administers or supervises the administration of the State's health planning functions under a State plan approved under section 314(a), each entity within the State which has developed a comprehensive regional, metropolitan, or other local area plan or plans referred to in section 314(b), and each regional medical program established in the State under the title IX.

(3) (A) Within two hundred and ten days after the date of enactment of this title, the Secretary shall publish as a notice in the Federal Register the health service area boundary designations. The boundaries for health service areas submitted by the Governors shall, except as otherwise provided in subparagraph (B), constitute upon their publication in the Federal Register the boundaries for such health service areas.

(B) (i) If the Secretary determines that a boundary submitted to him for a health service area does not meet the requirements of subsection (a), he shall, after consultation with the Governor who submitted such boundary, make such revision in the boundary for such area (and as necessary, in the boundaries for adjoining health service areas) as may be necessary to meet such requirements and publish such revised boundary (or boundaries); and the revised boundary (or boundaries) shall upon publication in the Federal Register constitute the boundary (or boundaries) for such health service area (or areas). The Secretary shall notify the Governor of each State in which is located a health service area whose boundary is revised under this clause of the boundary revision and the reasons for such revision.

(ii) In the case of areas of the United States not included within the boundaries for health service areas submitted to the Secretary as requested under the notice under paragraph (1), the Secretary shall establish and publish in the Federal Register health service area boundaries which include such areas. The Secretary shall notify the Governor of each State in which is located a health service area the

boundary for which is established under this clause of the boundaries established. In carrying out the requirement of this clause, the Secretary may make such revisions in boundaries submitted under subparagraph (A) as he determines are necessary to meet the requirement of subsection (a) for the establishment of health service areas throughout the United States.

[(4) The Secretary shall review on a continuing basis and at the request of any Governor or designated health systems agency the appropriateness of the boundaries of the health service areas established under paragraph (3) and, if he determines that a boundary for a health service area no longer meets the requirements of subsection (a), he may revise the boundaries in accordance with the procedures prescribed by paragraph (3)(B)(ii) for the establishment of boundaries of health service areas which include areas not included in boundaries submitted by the Governors. If the Secretary acts on his own initiative to revise the boundaries of any health service area, he shall consult with the Governor of the appropriate State or States, the entities referred to in paragraph (2), the appropriate health systems agency or agencies designated under part B and the appropriate Statewide Health Coordinating Council established under part C. A request for boundary revision shall be made only after consultation with the Governor of the appropriate State or States, the entities referred to in paragraph (2), the appropriate designated health systems agencies, and the appropriate established Statewide Health Coordinating Council and shall include the comments concerning the revision made by the entities consulted in requesting the revision.]

(4)(A) The Secretary shall review on his own initiative or at the request of any Governor or designated health systems agency the appropriateness of the boundaries of the health service areas established under paragraph (3) and, if he determines that the boundaries for a health service area no longer meet the requirements of subsection (a), or if the boundaries for a proposed revised health service area meet the requirements of subsection (a) in a significantly more appropriate manner in terms of the efficiency and effectiveness of health planning efforts, he shall revise the boundaries in accordance with the procedures prescribed by paragraph (3)(B)(ii). If the Secretary acts on his own initiative to revise the boundaries of any health service area, he shall consult with the Governor of the appropriate State or States, the chief executive officer or agency of the political subdivisions within the State or States that would be affected by the revision, the appropriate designated health systems agency or agencies and the appropriate established Statewide Health Coordinating Council. A Governor may request a revision of the boundaries of a health service area only after consultation with the Governor of any other appropriate State or States, the chief executive officer or agency of the political subdivisions within the State or States that would be affected by the revision, the appropriate designated health systems agencies, and the appropriate established Statewide Health Coordinating Council and shall include in such request the comments concerning the proposed revision made by such individuals and entities. A designated health systems agency may make a request to revise the boundaries of its health service area only after consultation with the Governor of the

appropriate State or States, the chief executive officer or agency of the political subdivisions within the State or States that would be affected by the revision, the other appropriate designated health system agency or agencies, and the appropriate established Statewide Health Coordinating Council and shall include in such request the comments concerning the proposed revision made by such individuals and entities. No proposed revision of the boundaries of a health service area shall comprise an entire State without the prior consent of the Governor of such State. In addition, for each proposed revision of the boundaries of a health service area, the Secretary shall give notice and an opportuntiy for a hearing on the record by all interested persons and make a written determination of his findings and decision.

(B) The Secretary shall, by January 1, 1979, by regulation establish criteria for the revision of the boundaries of health service areas.

(5) Within one year after the date of the enactment of this title the Secretary shall complete the procedures for the initial establishment of boundaries of health service areas which (except as provided in section 1536) include the geographic area of all the States.

[(c) Nothwithstanding any other requirement of this section, an area—

[(1) for which has been developed a comprehensive regional, metropolitan area, or other local area plan referred to in section 314(b), and

[(2) which otherwise meets the requirements of subsection (a), shall be designated by the Secretary as a health service area unless the Governor of any State in which such area is located, upon a finding that another area is a more appropriate region for the effective planning and development of health resources, waives such requirement.]

HEALTH SYSTEMS AGENCIES

Sec. 1512. (a) Definition.—For purposes of this title, the term "health systems agency" means an entity which is organized and operated in the manner described in subsection (b) and which is capable, as determined by the Secretary, of performing each of the functions described in section 1513. The Secretary shall by regulation establish standards and criteria for the requirements of subsection (b) and section 1513.*

(b)(1) Legal Structure.—A health systems agency for a health service area shall be—

(A) a nonprofit private corporation (or similar legal mechanism such as a public benefit corporation) which is incorporated in the State in which the largest part of the population of the health service area resides, which is not a subsidiary of, or otherwise controlled by, any other private or public corporation or other legal entity, and which only engages in health planning and development functions;

(B) a public regional planning body if (i) it has a governing board composed of a majority of elected officials of units of general local government or it is authorized by State law (in effect before the date of enactment of this subsection) to carry out

*Section 1512(b) Amendment's effective date is one year after enactment.

health planning and review functions such as those described in section 1513, and (ii) its planning area is identical to the health service area; or

(C) a single unit of general local government if the area of the jurisdiction of that unit is identical to the health service area.

A health systems agency may not be an educational institution or operate such an institution.

(2) STAFF.—

(A) EXPERTISE.—A health systems agency shall *to the extent practicable*, have a staff which provides the agency with expertise in at least the following: (i) Administration, (ii) the gathering and analysis of data, (iii) *health and mental health* planning, and (iv) development and use of [health resources] *health and mental health resources*. The functions of planning and of development of health resources shall be conducted by staffs with skills appropriate to each function. (*v*) *Financial and economic analysis* (*vi*) *public health and prevention of disease. At least one member of the staff shall be designated to have the responsibility of providing the consumer members of the governing body of an agency with such assistance as they may require to effectively perform their functions.*

(B) SIZE AND EMPLOYMENT.— The size of the professional staff of any health systems agency shall be not less than five, except that if the quotient of the population (rounded to the next highest one hundred thousand) of the health service area which the agency serves divided by one hundred thousand is greater than five, the minimum size of the professional staff shall be the lesser of (i) such quotient, or (ii) twenty-five. The members of the staff shall be selected, paid, promoted, and discharged in accordance with such system as the agency may establish, except that the rate of pay for any position shall not be less than the rate of pay prevailing in the health service area for similar positions in other public or private health service entities. If necessary for the performance of its functions, a health systems agency may employ consultants and may contract with individuals and entities for the provision of services. Compensation for consultants and for contracted services shall be established in accordance with standards established by regulation by the Secretary.

(3) GOVERNING BODY.—

(A) IN GENERAL.—A health systems agency which is a public regional planning body or unit of general local government shall, in addition to any other governing body, have a governing body for health planning, which is established in accordance with subparagraph (C), which shall have the responsibilities prescribed by subparagraph (B), and which has exclusive authority to perform for the agency the functions described in section 1513[.] "*except that a public regional planning body or unit of general local government which is a health systems agency is not required to delegate to its governing body for health planning the exclusive authority to—*

"(i) *appoint and with cause remove members of the governing body for health planning;*

"(ii) *establishes personnel rules and practices for the staff of the governing body for health planning;*

"(iii) *approve the agency's budget;* or,

"(iv) *any combination of the activities described in clauses (ii) and (iii).*"

Any other health systems agency shall have a governing body composed, in accordance with subparagraph (C), of not less than ten members and of not more than thirty members, except that the number of members may exceed thirty if the governing body has established another unit (refered to in this paragraph as an "executive committee") composed, in accordance with subparagraph (C), of not more than twenty-five members of the governing body and has delegated to that unit the authority to take such action (other than the establishment and revision of the plans referred to in subparagraph (B)(ii)) as the governing body is authorized to take.

(B) RESPONSIBILITIES.—The governing body—

(i) shall be responsible for the internal affairs of the health systems agency, including matters relating to the staff of the agency, the agency's budget, and procedures and criteria (developed and published pursuant to section 1532) applicable to its functions under subsections (e), (f), (g), and (h) of section 1513;

(ii) shall be responsible for the establishment of the health systems plan and annual implementation plan required by section 1513(b);

(iii) shall be responsible for the approval of grants and contracts made and entered into under section 1513(c)(3);

(iv) shall be responsible for the approval of all actions taken pursuant to subsections (e), (f), (g), and (h), of section 1513;

(v) shall (I) issue an annual report concerning the activities of the agency, (II) include in that report the health systems plan and annual implementation plan developed by the agency, and a listing of the agency's income, expenditures, assets, and liabilities, and (III) make the report readily available to the residents of the health service area and the various communications media serving such area;

(vi) shall [reimburse] (*or when appropriate*) *make advances to* its members and their reasonable costs incurred in attending meetings of the governing body *and performing any other duties and functions of the health systems agency;*

(vii) shall meet at least once in each calendar quarter of a year and shall meet at least two additional times in a year unless its executive committee meets at least twice in that year; and

(viii) shall (I) conduct its business meetings in public, *except for meetings or portions thereof called to discuss the performance or remuneration of an individual employee of the health systems agency which if public would constitute a clearly unwarranted invasion of the personal privacy of such employee.* (II) give adequate notice to the public of such

meeting, and (III) make its records and data, *except for personnel records and data regarding an individual employee the disclosure of which would constitute a clearly unwarranted invasion of the personal privacy of such employee*, available, upon request, to the public.

The governing body (and executive committee (if any)) of a health systems agency shall act only by vote of a majority of its members present and voting at a meeting called upon adequate notice to all of its members and at which a quorum is in attendance. A quorum for a governing body and executive committee shall not be less than one-half of its members.

(C) COMPENSATION.—The membership of the governing body and the executive committee (if any) of an agency shall meet the following requirements:

(i) a majority (but not more than 60 per centum of the members) shall be residents of the health service area served by the entity who are consumers of [health care] *health or mental health care* and who are not (*nor within the twelve months preceding appointment been*) providers of [health care] *health or mental health care* and who are broadly representative of the social, economic, linguistic and racial populations, geographic areas of the health service area, and major purchasers of [health care] *health or mental health care*, including but not limited to unions and corporations.

(ii) The remainder of the members shall be residents of *or have their principal place of business within* the health service area served by the agency who are providers of [health care] *health or mental health care* and who represent (I) physicians *including doctors of medicine and osteopathy* (particularly practicing physicians, dentists, nurses, and other health professionals), (II) [health care] *health or mental health care* institutions (particularly hospitals, long-term care facilities, *alcohol and drug* (substance) abuse treatment facilities, and health maintenance organizations), (III) [health care] *health or mental health care insurers*, (IV) health professional schools (and) (V) the allied health professions, *(VI) non-professional health workers and, (VII) other providers of health or mental health care.* Not less than one-third of the providers of [health care] *health or mental health care* who are members of the governing body or executive committee of a health systems agency shall be direct providers of [health care] *health or mental health care* (as described in section 1531(3)).

(iii) The membership shall—

(I) include (either through consumer or provider members) public elected officials [and other representatives of governmental authorities] *or other representatives of units of general purpose local government* in the agency's health service area and representatives of public and private agencies in the area concerned with health, *to be considered a representative of a unit of general purpose local government an individual must be appointed*

by such unit or a combination thereof. For the purpose of this clause, the State government of a State which is composed of a single health service area shall be deemed to be a unit of general purpose local government.

(II) include a percentage of individuals who reside in nonmetropolitan areas within the health service area which percentage is *at least* equal to the percentage of residents of the area who reside in nonmetropolitan areas, and

(III) if the health systems agency serves an area in which there is located one or more hospitals or other health care facilities of the Veterans' Administration, include, as [an] *a non-voting* ex officio member, an individual whom the Chief Medical Director of the Veterans' Administration shall have designated for such purpose, and if the agency serves an area in which there is located one or more qualified health maintenance organizations (within the meaning of section 1310), include at least one member who is representative of such organizations.

(iv) If, in the exercise of its functions, a governing body or executive committee appoints a subcommittee (of its members) or an advisory group, it shall (to the extent practicable), make its appointments to any such subcommittee or group in such a manner as to provide [the representation on such subcommittee or group described in this subparagraph] *that a majority of the members of any such subcommittee or group are consumers of health or mental health care.*

(4) INDIVIDUAL LIABILITY.—No individual who, as a [member or employee] *member employee, consultant or agent* of a health systems agency, shall, by reason of his performance of any duty, function, or activity required of, or authorized to be undertaken by, the agency under this title, be liable for the payment of damages under any law of the United States or any State (or political subdivision thereof) (if he has acted within the scope of such duty, function, or activity, has exercised due care, and has acted, with respect to that performance, without malice toward any person affected by it). *If he could have reasonably believed he was acting within the scope of such duty, function, or activity, and acted, with respect to that performance without gross negligence or malice toward any person affected by it.*

(5) PRIVATE CONTRIBUTIONS.—No health systems agency may accept any funds or contributions of services or facilities from any individual or private entity which has a financial, fiduciary, or other direct interest in the development, expansion, or support of health resources unless, in the case of an entity, it is an organization described in section 509(a) of the Internal Revenue Code of 1954 and is not directly engaged in the provision of health care in the health service area of the agency. For purposes of this paragraph, an entity shall not be considered to have such an interest solely on the basis of its providing (directly or indirectly) health care for its employees.

(6) OTHER REQUIREMENTS.—Each health system agency shall—

(A) provide that any executive committee of the agency and any entity appointed by the governing body or executive committee of the agency and any subarea advisory council shall (i)

conduct its business meetings in public (except for meetings or portions thereof called to discuss the performance or remuneration of an individual employee which if public would constitute a clearly unwarranted invasion of the personal privacy of such employee), (ii) give adequate notice of its meetings to those persons who have requested such notice, and (iii) make its records and data available, upon request, to the public (other than personnel records and data regarding an individual employee the disclosure of which would constitute a clearly unwarranted invasion of the personal privacy of such employee);

[(A)] (*B*) make such reports, in such form and containing such information, concerning its structure, operations, performance of functions, and other matters as the Secretary may from time to time require, and keep such records and afford such access thereto as the Secretary may find necessary to verify such reports;

[(B)] (*C*) provide for such fiscal control and fund accounting procedures as the Secretary may require to assure proper disbursement of, and accounting for, amounts received from the Secretary under this title and section 1640; and

[(C)] (*D*) permit the Secretary and the Comptroller General of the United States, or their representatives, to have access for the purpose of audit and examination to any books, documents, papers, and records pertinent to the disposition of amounts received from the Secretary under this title and section 1640.

(7) *Conflict of Interest.—Each health systems agency shall adopt procedures in accordance with regulations promulgated by the Secretary to insure that no member, employee, consultant or agent participates in any matter regarding any person, institution, organization or other entity with which he or she has or has had within the past three years any substantial direct or indirect employment, fiduciary, competitive, medical staff, or ownership or other financial interest.".*

(c) Subarea Councils.—A health systems agency may establish subarea advisory councils representing parts of the agency's health service area to advise the governing body of the agency on the performance of its functions. The composition of a subarea advisory council shall conform to the requirements of subsection (b)(3)(C).

(d) *Selection.—Each health systems agency shall establish a process for the selection of the members of its governing body and any subarea advisory councils which process is designed to assure that (i) such members are selected in accordance with the requirements of subparagraph (C), (ii) there is the opportunity for broad participation in such process by the residents of the health service area of the agency, and (iii) the participation of such residents will be encouraged and facilitated. Such process shall prohibit the selection of members of such body by members of such body and members of such councils by members of such council. Each agency shall make public such process and report it to the Secretary.".*

FUNCTIONS OF HEALTH SYSTEMS AGENCIES

Sec. 1513. (a) For the purpose of—

(1) improving the health of residents of a health service area,

(2) increasing the accessibility (including overcoming geo-

graphic, architectural, and transportation barriers), acceptability, continuity, and quality of the health services provided them,

(3) restraining increases in the cost of providing them health services, and

(4) preventing unnecessary duplication of health resources,

each health systems agency shall have as its primary responsibility provision of effective health planning for its health service area and the promotion of the development within the area of health services, manpower, and facilities which meet identified needs, reduce documented inefficiencies, and implement the health plans of the agency. To meet its primary responsibility, a health systems agency shall carry out the functions described in subsections (b) through (h) of this section.

(b)* In providing health planning and resources development for its health service area, a health systems agency shall perform the following functions:

(1) The agency shall assemble and analyze data concerning--

(A) the status (and its determinants) of the health of the residents of its health service area,

(B) the status of the health care delivery system in the area and the use of that system by the residents of the area,

(C) the effect the area's health care delivery system has on the health of the residents of the area,

(D) the number, type, and location of the area's health resources, including health services, manpower, and facilities,

(E) the patterns of utilization of the area's health resources, and

(F) the environmental and occupational exposure factors affecting immediate and long term health conditions.

In carrying out this paragraph, the agency shall to the maximum extent practicable use existing data (including data developed under Federal health programs) and coordinate its activities with the cooperative system provided for under section 306(e).

(2) The agency shall, after appropriate consideration of the recommended national guidelines for health planning policy issued by the Secretary under section 1501, the priorities set forth in section 1502, and the data developed pursuant to paragraph (1), *(in accordance with the format prescribed pursuant to section 1524(c)(1)*, annually review, and amend as necessary a health system plan (hereinafter in this title referred to as the "HSP") which shall be a detailed statement of goals (A) describing a healthful environment and health systems in the area which, when developed, will assure that quality health services will be available and accessible in a manner which assures continuity of care, at reasaonable cost, for all residents of the area; (B) which are responsive to the unique needs and resources of the area; [and] (C) which take into account and are consistent with the national guidelines for health planning policy issued by the Secretary under section 1501 respecting supply, distribution, and organization of health resources and services[.] *"; (D) which describe the institutional health services (as defined in section 1531(5))*

*Section 1513(b) amendment effective date is one year after enactment.

needed to provide for the well-being of persons receiving care within the health service area including, at a minimum, the number and type of medical facilities, rehabilitation facilities, nursing homes, beds, and equipment needed to provide acute inpatient, psychiatric inpatient, obstetrical inpatient, neonatal inpatient, long term care, and treatment for alcohol and drug abuse; the extent to which existing medical facilities, rehabilitative facilities, nursing homes, beds and equipment are in need of modernization or conversion to new uses; and, the extent to which new medical facilities, rehabilitative facilities, nursing homes, beds and equipment need to be constructed or acquired; (E) which describe other health services (other than institutional health services as defined in section 1531(5)) needed to provide for the well-being of persons receiving care within the health service area including, at a minimum, the number and type of health maintenance organizations, outpatient (including primary care), rehabilitation facilities, facilities for the treatment of alcohol abuse and drug abuse, and other medical facilities, and home health agencies and patient care and the extent to which such outpatient and other facilities and equipment are in need of modernization or conversion to new uses and the extent to which new health maintenance organizations, outpatient and other facilities, home health agencies and equipment need to be constructed or acquired. The HSP shall include identifiable alcohol abuse, drug abuse, and mental health components, and shall address specifically the needs of all medical underserved populations in the health service area. Before establishing an HSP , *in the process of annually reviewing an HSP, and before amending an HSP,* a health systems agency shall conduct a public hearing on the proposed HSP and shall give interested persons an opportunity to submit their views orally and in writing. Not less than thirty days prior to such hearing, the agency shall publish in at least two newspapers of general circulation throughout its health service area a notice of its consideration of the proposed HSP, the time and place of the hearing, the place at which interested persons may consult the HSP in advance of the hearing, and the place and period during which to submit written comments to the agency on the HSP.

(3) The agency shall establish, annually review, and amend as necessary an annual implementation plan (hereinafter in this title referred to as the "AIP") which describes objectives which will achieve the goals of the HSP (*as revised pursuant to section 1524 (c) (2) (A)*) and priorities among the objectives. In establishing the AIP, the agency shall give priority to those objectives which will maximally improve the health of the residents of the area, as determined on the basis of the relation of the cost of attaining such objectives to their benefits, and which are fitted to the special needs of the area. *The AIP shall be established, annually reviewed, and amended in accordanc with the procedures set forth in the last two sentences of paragraph (2).*

(4) The agency shall develop and publish specific plans and projects for achieving the objectives established in the AIP.

(c) A health systems agency shall implement its HSP and AIP, and in implementing the plans it shall perform at least the following functions:

(1) The agency shall seek, to the extent practicable, to implement its HSP and AIP with the assistance of individuals and public and private entities in its health service area.

(2) The agency [may] *shall* provide, in accordance with the priorities established in the AIP, technical assistance *in obtaining and filling out the necessary forms and may provide other technical assistance* to individuals and public and private entities for the development of projects and programs which the agency determines are necessary to achieve the health systems described in the HSP, including assistance in meeting the requirements of the agency prescribed under section 1532(b).

(3) The agency shall, in accordance with the priorities established in the AIP, make grants to public and nonprofit private entities and enter into contracts with individuals and public and nonprofit private entities to assist them in planning and developing projects and programs which the agency determines are necessary for the achievement of the health systems described in the HSP. Such grants and contracts shall be made from the Area Health Services Development Fund of the agency established with funds provided under grants made under section 1640. No grants or contract under this subsection may be used (A) to pay the costs incurred by an entity or individual in the delivery of health services (as defined in regulations of the Secretary), or (B) for the cost of construction or modernization of medical facilities. No single grant or contract made or entered into under this paragraph shall be available for obligation beyond the one year period beginning on the date the grant or contract was made or entered into. If an individual or entity receives a grant or contract under this paragraph for a project or program, such individual or entity may receive only one more such grant or contract for such project or program *except that if such grant or contract is reviewed, funds may be carried forward to the subsequent grant or contract period without being deducted from the amount of the subsequent grant or contract.*

(d) Each health systems agency shall coordinate its activities with—

(1) each Professional Standards Review Organization (designated under section 1152 of the Social Security Act),

(2) entities referred to in paragraphs (1) and (2) of section 204(a) of the Demonstration Cities and Metropolitan Development Act of 1966 and regional and local entities the views of which are required to be considered under regulations prescribed under section 403 of the Intergovernmental Cooperation Act of 1968 to carry out section 401(b) of such Act,

(3) other appropriate general or special purpose regional planning or administrative agencies [and] (*including local and regional alcohol abuse, drug abuse, and mental health planning agencies*),

(4) any entity of the state in which the agency is located which which reviews the rates and budgets of health care facilities located in the agency's health service area, and

[(4)] *(5)* any other appropriate entity

in the health systems agency's health service area. The agency shall, as appropriate, secure data from them for use in the agency's planning and development activities, enter into agreement with them which will assure that actions taken by such entities which alter the area's health systems will be taken in a manner which is consistent with the HSP and the AIP in effect for the area, and, to the extent practicable, provide technical assistance to such entities.

(e)(1)(A) Except as provided in subparagraph (B), each health systems agency shall review and approve or disapprove each proposed use within its health service area of Federal funds—

(i) appropriated under this Act, the Community Mental Health Centers Act, sections 409 and 410 of the Drug Abuse Office and Treatment Act, or the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 for grants, contracts, loans, or loan guarantees for the development, expansion, or support of health resources; or

(ii) made available by the State in which the health service area is located (from an allotment to the State under an Act referred to in clause (i)) for grants or contracts for the development, expansion, or support of health resources.

(B) A health systems agency shall not review and approve or disapprove the proposed use within its health service area of Federal funds appropriated for grants or contracts under title IV, VII, or VIII of this Act unless the grants or contracts are to be made, entered into, or used to support the development of health resources [intended for use in the health service] *that would make a significant change in the health services offered within the health service* area or [the delivery of health services.] *to support the delivery of health services which would make a significant change in the health services offered in the health service area.* In the case of a proposed use within the health service area of a health systems agency of Federal funds described in subparagraph (A) by an Indian (*as defined in section 4(b) of the Indian Self-Determination and Education Assistance Act*) tribe or inter-tribal Indian organization for any program or project which will be located within or will specifically serve—

(i) a federally-recognized Indian reservation.

(ii) any land area in Oklahoma which is held in trust by the United States for Indians or which is a restricted Indian-owned land area, or

(iii) a Native village in Alaska (as defined in section 3(c) of the Alaska Native Claims Settlement Act),

a health systems agency shall only review and comment on such proposed use.

(2) When a health systems agency is requested by or on behalf of a Federal department or agency to review a proposed use of Federal funds, other than those specified in subparagraph (A), to support the development of institutional health services intended for use in the health service area, the health systems agency shall, within sixty days

of receiving such a request, submit its views on such proposed use to the Federal department or agency involved and to the appropriate Committees of the Congress, and

[(2)] *(3)* Notwithstanding any other provision of this Act or any other Act referred to in paragraph (1), the Secretary shall allow a health systems agency sixty days to make the review required by such paragraph. If any agency disapproves a proposed used in its health service area of Federal funds described in paragraph (1), the Secretary may not make such Federal funds available for such use until he has made, upon request of the entity making such proposal, a review of the agency decision. In making any such review of any agency decision, the Secretary shall give the appropriate State health planning and development agency an opportunity to consider the decision of the health systems agency and to submit to the Secretary its comments on the decision. The Secretary, after taking into consideration such State agency's comments (if any), may make such Federal funds available for such use, notwithstanding the disapproval of the health systems agency. Each such decision by the Secretary to make funds available shall be submitted to the appropriate health systems agency and State health planning and development agency and shall contain a detailed statement of the reasons for the decision.

[(3)] *(4)* Each health systems agency shall provide each Indian tribe or inter-tribal Indian organization which is located within the agency's health service area information respecting the availability of the Federal funds described in the first sentence of this subsection.

(5) Health systems agencies that have an Indian tribe or inter-tribal Indian organization (referred to in paragraph (1)(B)) located within such agencies' health service areas shall carry out their functions under this section in a manner that recognizes tribal self-determination. Such agencies shall seek to enter into agreements with the Indian tribes and/or inter-tribal organizations located within their health service areas on matters of mutual concern as defined in regulations of the Secretary.

(f) To assist State health planning and development agencies in carrying out their functions under paragraphs (4) and (5) of section 1523(a) each health systems agency shall review and make recommendations to the appropriate State health planning and development agency respecting the need for new institutional health services proposed to be offered or developed in the health service area of such health systems agency.

(g)(1) Except as provided in paragraph (2), each health systems agency shall review on a periodic basis (but at least every five years) [all] *at least those* institutional health services *identified in the state health plan prepared pursuant to section 1524(c)(2)* offered in the health service area of the agency shall make recommendations to the State health planning and development agency designated under section 1521 for each State in which the health systems agency's health service area is located respecting the appropriateness in the area of such services.

(2) A health systems agency shall complete its initial review of existing institutional health services within three years after the date of the agency's designation under section 1515(c).

3. In making the appropriateness review required by paragraph (1), each health systems agency shall address at a maximum issues of need, accessibility, financial viability, cost effectiveness, costs and charges to the public, and quality of service provided.

(h) Each health systems agency shall annually recommend to the State health planning and development agency designated for each State in which the health systems agency's health service area is located (1) projects for the modernization, construction, and conversion of medical facilities in the agency's health service area which projects will achieve the HSP and AIP of the health systems agency, and (2) priorities among such projects.

ASSISTANCE TO ENTITIES DESIRING TO BE DESIGNATED AS HEALTH SYSTEMS AGENCIES

SEC. 1514. The Secretary [may] *shall* provide all necessary technical and other nonfinancial assistance (including the preparation of prototype plans of organization and operation) to public or nonprofit private entities (including entities presently receiving financial assistance under section 314(b) or title IX or as experimental health service delivery systems under section 304) which—

(1) express a desire to be designated as health systems agencies, and

(2) the Secretary determines have a potential to meet the requirements of a health systems agency specified in sections 1512 and 1513.

to assist such entities in developing applications to be submitted to the Secretary under section 1515 and otherwise in preparing to meet the requirements of this part for designation as a health systems agency.

DESIGNATION OF HEALTH SYSTEMS AGENCIES

SEC. 1515. (a) At the earliest practicable date after the establishment under section 1511 of health service areas (but not later than eighteen months after the date of enactment of this title) the Secretary shall enter into agreements in accordance with this section for the designation of health systems agencies for such areas.

(b)(1) The Secretary may enter into agreements with entities under which the entities would be designated as the health systems agencies for health service areas on a conditional basis with a view to determining their ability to meet the requirements of section 1512(b), and their capacity to perform the functions prescribed by section 1513.

(2) During any period of conditional designation (which, except as otherwise provided in this paragraph, may not exceed 24 months), the Secretary may require that the entity conditionally designated meet only such of the requirements of section 1512(b) and perform only such of the functions prescribed by section 1513 as he determines such entity to be capable of meeting and performing. The Secretary may, upon application of a conditionally designated entity, extend for an additional period of not to exceed 12 months the period of such entity's conditional designation if the Secretary determines that (A) unusual circumstances exist or existed which prevent such entity from qualifying for designation under subsection (c) within 24 months of

such entity's conditional designation under this subsection, (B) such extension should enable such entity to qualify for designation under subsection (c), and (C) such extension is necessary to carry out the purposes of this title. Each such determination shall be in writing and shall include a summary of the reasons for it. The number and type of such requirements and functions shall, during the period of conditional designation, be progressively increased as the entity conditionally designated becomes capable of added responsibility so that, by the end of such period, the agency may be considered for designation under subsection (c).

(3) Any agreement under which any entity is conditionally designated as a health systems agency may be terminated by such entity upon ninety days notice to the Secretary or by the Secretary upon ninety days notice to such entity.

(4) The Secretary may not enter into an agreement with any entity under paragraph (1) for conditional designation as a health systems agency for a health service area until—

(A) the entity has submitted an application for such designation which contains assurances satisfactory to the Secretary that upon completion of the period of conditional designation the applicant will be organized and operated in the manner described in section 1512(b) and will be qualified to perform, the functions prescribed by section 1513;

(B) a plan for the orderly assumption and implementation of the functions of a health systems agency has been received from the applicant and approved by the Secretary; and

(C) the Secretary has consulted with the Governor of each State in which such health service area is located and with such other State and local officials as he may deem appropriate, with respect to such designation.

[In considering such applications, the Secretary shall give priority to an application which has been recommended for approval by each entity which has developed a plan referred to in section 314(b) for all or part of the health service area with respect to which the application was submitted, and each regional medical program established in such area under title IX.]

(c) (1) The Secretary shall enter into an agreement with an entity for its designation as a health systems agency if, on the basis of an application under paragraph (2) (and, in the case of an entity conditionally designated, on the basis of its performance during a period of conditional designation under subsection (b) as a health systems agency for a health service area), the Secretary determines that such entity is capable of fulfilling, in a satisfactory manner, the requirements and functions of a health systems agency. Any such agreement under this subsection with an entity may be renewed in accordance with paragraph (3), shall contain such provisions respecting the requirements of sections 1512(b) and 1513 and such conditions designed to carry out the purpose of this title, as the Secretary may prescribe, and shall be for a term of not to exceed [twelve months] *three years;* except that, prior to the expiration of such term, such agreement may be terminated—

(A) by the entity at such time and upon such notice to the Secretary as he may by regulation prescribe, or

(B) by the Secretary, at such time and upon such notice to the entity as the Secretary may by regulation prescribe, if the Secretary determines that the entity is not complying with or effectively carrying out the provisions of such agreement.

(2) The Secretary may not enter into an agreement with any entity under paragraph (1) for designation as a health systems agency for a health service area unless the entity has submitted an application to the Secretary for designation as a health systems agency, and the Governor of each State in which the area is located has been consulted respecting such designation of such entity. Such an application shall contain assurances satisfactory to the Secretary that the applicant meets the requirements of section 1512(b) and is qualified to perform or is performing the functions prescribed by section 1513. [In considering such applications the Secretary shall give priority to an application which has been recommended for approval by (A) each entity which has developed a plan referred to in section 314(b) for all or part of the health service area with respect to which the application was submitted, and (B) each regional medical program established in such area under title IX.]

(3)(*A*) An agreement under this subsection for the designation of a health systems agency may be renewed by the Secretary for a period not to exceed [twelve months]; three years if upon review (as provided in section 1535) of the agency's operation and performance of its functions, he determines that it has fulfilled, in a satisfactory manner, the functions of a health systems agency prescribed by section 1513 *during the period of the agreement to be reviewed* and continues to meet the requirements of section 1512(b).

(*B*) *If upon review (as provided in section 1535) of the agency's operation and performance of its functions, the Secretary determines that it has not fulfilled, in a satisfactory manner, the functions of a health systems agency prescribed by section 1513 during the period of the agreement to be renewed or does not continue to meet the requirements of section 1512(b), he may terminate such agreement or return such agency to a conditionally designated status under subsection (b) for a period not to exceed twelve months. At the end of such period, the Secretary shall either terminate its agreement with such agency or enter into an agreement with such agency under paragraph (1).*

(d) If a designation *agreement* under subsection (b) or (c) of a health systems agency for a health service area is terminated before the date prescribed for its expiration, *or is not reviewed*, the Secretary shall, upon application and in accordance with subsection (b) or (c) (as the Secretary determines appropriate), enter into a designation agreement with another entity to be the health systems agency for such area.

PLANNING GRANTS

SEC. 1516. (a) The Secretary shall make in each fiscal year a grant to each health systems agency with which there is in effect a designation agreement under subsection (b) or (c) of section 1515. A grant under this subsection shall be made on such conditions as the Secretary determines is appropriate, shall be used by a health systems agency for compenation of agency personnel, collection of data, planning, and the performance of the functions of the agency, and shall be available

for obligation for a period not to exceed the period for which its designation agreement is entered into or [renewed (as the case may be)], *in the event that the grant is reviewed, it may be carried forward to the subsequent grant period without being deducted from the subsequent grant award*, except that in the case of a grant made to a conditionally designated entity with which the Secretary will not enter into a designation agreement under section 1515(c), such grant shall be available for obligation for such additional period as the Secretary determines such entity will require to satisfactorily terminate its activities under the agreement for its conditional designation. A health systems agency may use funds under a grant under this subsection to make payments under contracts with other entities to assist the health systems agency in the performance of its functions; but it shall not use funds under such a grant to make payments under a grant or contract with another entity for the development or delivery of health services or resources.

(b)(1) The amount of any grant under subsection (a) to a health systems agency designated under section 1515(b) shall be determined by the Secretary. The amount of any grant under subsection (a) to any health systems agency designated under section 1515(c) shall be the lesser of—

(A) the product of $0.50 and the population of the health service area for which the agency is designated, or

(B) $3,750,000,

unless the agency would receive a greater amount under paragraph (2) or (3).

(2)(A) If the application of a health systems agency for such a grant contains assurances satisfactory to the Secretary that the agency will expend or obligate in the period in which such grant will be available for obligation non-Federal funds meeting the requirements of subparagraph (B) for the purposes for which such grant may be made, the amount of such grant shall be the sum of—

(i) the [amount determined under paragraph (1),] *greater of (I) the amount determined under paragraph (1) without regard to this paragraph or paragraph (3), or (II) the amount determined under paragraph (3)*, and

(ii) the lesser of (I) the amount of such non-Federal funds with respect to which the assurances were made, or (II) the product of $0.25 and the population of the health service area for which the agency is designated.

(B) The non-Federal funds which an agency may use for the purpose of obtaining a grant under subsection (a) which is computed on the basis of the formula prescribed by subparagraph (A) shall—

(i) not include any funds contributed to the agency by any individual or private entity which has a financial, fiduciary, or other direct interest in the development, expansion, or support of health resources, and

(ii) be funds which are not paid to the agency for the performance of particular services by it and which are otherwise contributed to the agency without conditions as to their use other than the condition that the funds shall be used for the purposes for which a grant made under this section may be used.

(3) The amount of a grant under subsection (a) to a health systems agency designated under section 1515(c) may not be less than [$175,000] *$250,000 in the fiscal year ending September 30, 1979, $270,000 the fiscal year ending September 30, 1980, and $290,000 in any succeeding fiscal year.*

(c)(1) For the purpose of making payments pursuant to grants made under subsection (a), there are authorized to be appropriated $60,000,000 for the fiscal year ending June 30, 1975, $90,000,000 for the fiscal year ending June 30, 1976, [and] $125,000,000 each for the fiscal years ending September 30, 1977, and September 30, 1978, $150,000,000 for the fiscal year ending September 30, 1979, $275,000,000, for the fiscal year ending September 30, 1980, and $200,000,000, for the fiscal year ending September 30, 1981.

(2) Of the amount appropriated under paragraph (1) for any fiscal year, the Secretary may use not more than 5 per centum of such amount to increase the amount of a grant in such fiscal year to a health systems agency under subsection (a) to assist the agency in meeting extraordinary expenses (including, but not limited to, extraordinary expenses resulting from the agency's health systems area being located in more than one State or from the agency serving a large rural or urban medical underserved population, or a large health service area) which would not be covered under the amount of the grant that would be available to the agency under this subsection.

[(2)] *(3)* Notwithstanding subsection (b), if the total of the grants to be made under this section to health systems agencies for any fiscal year exceeds the total of the amounts appropriated under paragraph (1) for that fiscal year, the amount of the grant for that fiscal year to each health systems agency shall be an amount which bears the same ratio to the amount determined for that agency for that fiscal year under subsection (b) as the total of the amounts appropriated under paragraph (1) for that fiscal years bears to the total amount required to make grants to all health systems agencies in accordance with the applicable provision of subsection (b) [: except that the amount of any grant to a health systems agency for any fiscal year shall not be less than $175,000, unless the amount appropriated for that fiscal year under paragraph (1) is less than the amount required to make such a grant to each health systems agency.]

Part C—State Health Planning and Development

designation of state health planning and development agencies

Sec. 1521. (a) For the purpose of the performance within each State of the health planning and development functions prescribed by section 1523, the Secretary shall enter into and renew agreements (described in subsection (b)) for the designation of a State health planning and development agency for each State.

(b)(1) A designation agreement under subsection (a) is an agreement with the Governor of a State for the designation of an agency (selected by the Governor) of the government of that State as the State health planning and development agency (hereinafter in this

part referred to as the "State Agency") to administer the State administrative program prescribed by section 1522 and to carry out the State's health planning and development functions prescribed by section 1523. The Secretary may not enter into such an agreement with the Governor of a State unless—

(A) there has been submitted by the State a State administrative program which has been approved by the Secretary,

(B) an application has been made to the Secretary for such an agreement and the application contains assurances satisfactory to the Secretary that the agency selected by the Governor for designation as the State Agency has the authority and resources to administer the State administrative program of the State and to carry out the health planning and development functions prescribed by section 1523, and

(C) in the case of an agreement entered into under paragraph (3), there has been established for the State a Statewide Health Coordinating Council meeting the requirements of section 1524.

(2)(A) The agreement entered into with a Governor of a State under subsection (a) may provide for the designation of a State Agency on a conditional basis with a view to determining the capacity of the designated State Agency to administer the State administer program of the State and to carry out the health planning and development functions prescribed by section 1523. The Secretary shall require as a condition to the entering into of such an agreement that the Governor submit on behalf of the agency to be designated a plan for the agency's orderly assumption and implementation of such functions.

(B) The period of an agreement described in subparagraph (A) may not exceed thirty-six months. During such period the Secretary may require that the designated State Agency perform only such of the functions of a State Agency prescribed by section 1523 as he determines it is capable of performing. The number and type of such functions shall, during such period, be progressively increased as the designated State Agency becomes capable of added responsiblity, so that by the end of such period the designated State Agency may be considered for designation under paragraph (3).

(C) Any agreement with a Governor of a State entered into under subparagraph (A) may be terminated by the Governor upon ninety days' notice to the Secretary or by the Secretary upon ninety days' notice to the Governor.

(3) If, on the basis of an application for designation as a State Agency (and, in the case of an agency conditionally designated under paragraph (2), on the basis of its performance under an agreement with a Governor of a State entered into under such paragraph), the Secretary determines that the agency is capable of fulfilling, in a satisfactory manner, the responsibilities of a State Agency, he shall enter into an agreement with the Governor of the State designating the agency as the State Agency for the State. No such agreement may be made unless an application therefor is submitted to, and approved by, the Secretary. Any such agreement shall be for a term of not to exceed [twelve months] *three years*, except that, prior to expiration of such term, such agreement may be terminated—

(A) by the Governor at such time and upon such notice to the Secretary a he may by regulation prescribe, or

(B) by the Secretary, at such time and upon such notice to the Governor as the Secretary may by regulation prescribe if the Secretary determines that the designated State Agency is not complying with or effectively carrying out the provisions of such agreement.

An agreement under this paragraph shall contain such provisions as the Secretary may require to assure that the requirements of this part respecting State Agencies are complied with.

(4) (*A*) An agreement entered into under paragraph (3) for the designation of a State Agency may be renewed by the Secretary for a period not to exceed [twelve months] *three years* if he, *upon review (as provided in Section 1535) of the State agency's operation and performance of its functions*, determines that it has fulfilled, in a satisfactory manner, the responsibilities of a State Agency during the period of the agreement to be renewed and if the applicable State administrative program continues to meet the requirements of section 1522.

(B) If upon review (as provided in section 1535) of the State Agency's operation and performance of its functions, the Secretary determines that it has not fulfilled, in a satisfactory manner, the responsibilities of a State Agency during the period of the agreement to be renewed or if the applicable State administrative program does not continue to meet the requirements of section 1522, he may terminate such agreement or return the State Agency to a conditionally designated status under paragraph (2) of subsection (b) for a period not to exceed twelve months. At the end of such period, the Secretary shall either terminate its agreement with such State Agency or enter into an agreement with such State Agency under paragraph (3) of subsection (b).

(c) If a designation agreement with the Governor of a State entered into under subsection (b) (2) or (b) (3) is terminated before the date prescribed for its expiration, the Secretary shall, upon application and in accordance with subsection (b) (2), or (b) (3) (as the Secretary determines appropriate), enter into another agreement with the Governor for the designation of a State Agency.

(d) [If, upon the expiration of the fourth fiscal year which begins after the calendar year in which the National Health Planning and Resources Development Act of 1974 is enacted, an agreement under this section for the designation of a State Agency for a State is not in effect, the Secretary may not make any allotment, grant, loan, or loan guarantee, or enter into any contract, under this Act, the Community Mental Health Centers Act, or the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 for the development, expansion, or support of health resources in such State until such time as such an agreemnt is in effect.] *If an agreement under this section for the designation of a State Agency for a State is not in effect by September 30, 1980, the Secretary shall reduce by 25 per centum the amount of any allotment, grant, loan, loan guarantee to be made and the amount, if any, of any contract to be entered into under this Act, the Community Mental Health Centers Act, or the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 for the development, expansion, or support of health resources in such State until such time as*

such an agreement is in effect. If such an agreement is not in effect by September 30, 1981, the Secretary shall reduce such amounts by 50 per centum until such time as such an agreement is in effect. If such an agreement is not in effect by September 30, 1982, the Secretary shall reduce such amounts by 75 per centum until such time as such an agreement is in effect. If such an agreement is not in effect by September 30, 1983, the Secretary shall reduce such amounts by 100 per centum until such time as such an agreement is in effect.

STATE ADMINISTRATIVE PROGRAM

SEC. 1522. (a) A State administrative program (hereinafter in this section referred to as the "State Program") is a program for the performance within the State by its State Agency of the functions prescribed by section 1523. The Secretary may not approve a State Program for a State unless it—

(1) meets the requirements of subsection (b);

(2) has been submitted to the Secretary by the Governor of the State at such time and in such detail, and contains or is accompanied by such information, as the Secretary deems necessary; and

(3) has been submitted to the Secretary only after the Governor of the State has afforded to the general public of the State a reasonable opportunity for a presentation of views on the State Program.

(b) The State Program of a State must—

(1) provide for the performance within the State (after the designation of a State Agency and in accordance with the designation agreement) of the functions prescribed by section 1523 and specify the State Agency of the State as the sole agency for the performance of such functions (except as provided in subsection (b) of such section) and for the administration of the State Program;

(2) contain or be supported by satisfactory evidence that the State Agency has under State law the authority to carry out such functions and the State Program in accordance with this part and contain a current budget for the operation of the State Agency;

(3) provide for adequate consultation with, and authority for, the Statewide Health Coordinating Council (prescribed by section 1524), in carrying out such functions and the State Program;

(4) (A) set forth in such detail as the Secretary may prescribe the qualifications for personnel having responsibilities in the performance of such functions and the State Program, and require the State Agency to have a professional staff for planning and a professional staff for development, which staffs shall be of such size and meet such qualifications as the Secretary may prescribe;

(B) provide for such methods of administration as are found by the Secretary to be necessary for the proper and efficient administration of such functions and the State Program, including methods relating to the establishment and maintenance of personnel standards on a merit basis consistent with such standards as are or may be established by the Civil Service Commission under section 208(a) of the Intergovernmental Personnel Act of 1970 (Pub-

lic Law 91–648), but the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with the methods relating to personnel standards on a merit basis established and maintained in conformity with this paragraph;

(5) require the State Agency to perform its functions in accordance with procedures and criteria established and published by it, which procedures and criteria shall conform to the requirements of section 1532;

(6) require the State Agency to (A) conduct its business meetings in public, *except for meetings or portions thereof called to discuss the performance or remuneration of an individual employee of the State agency which if public would constitute a clearly unwarranted invasion of the personal privacy of such employee*, (B) give adequate notice to the public of such meetings, and (C) make its records and data, *except for personnel records, and data regarding an individual employee the disclosure of which would constitute a clearly unwarranted invasion of the personal privacy of such employee*, available, upon request, to the public;

(7) (A) provide for the coordination (in accordance with regulations of the Secretary) with the cooperative system provided for under section 306(e) of the activities of the State Agency for the collection, retrieval, analysis, reporting, and publication of statistical and other information related to health and health care, *and for the coordination by the State Agency in the conduct of its activities with any entity of the State which reviews the rates and budgets of health care facilities in the State* and (B) require providers of health care doing business in the State to make statistical and other reports of such information to the State Agency;

(8) provide, in accordance with methods and procedures prescribed or approved by the Secretary, for the evaluation, at least annually, of the performance by the State Agency of its functions and of their economic effectiveness;

(9) provide that the State Agency will from time to time, and in any event not less often than annually, review the State Program and submit to the Secretary required modifications;

(10) require the State Agency to make such reports, in such form and containing such information, concerning its structure, operations, performance of functions, and other matters as the Secretary may from time to time require, and keep such records and afford such access thereto as the Secretary may find necessary to verify such reports;

(11) require the State Agency to provide for such fiscal control and fund accounting procedures as the Secretary may require to assure proper disbursement of, and accounting for, amounts received from the Secretary under this title;

(12) permit the Secretary and the Comptroller General of the United States, or their representatives, to have access for the purpose of audit and examination to any books, documents, papers, and records of the State Agency pertinent to the disposition of amounts received from the Secretary under this title; and

27-409 O - 78 - 9

(13) provide that if the State Agency makes a decision in the performance of a function under paragraph (3), (4), (5), or (6) of section 1523(a) or under title XVI which is inconsistent with a recommendation made under subsection (f), (g), or (h) of section 1513 by a health systems agency within the State—

(A) such decision (and the record upon which it was made) shall, upon request of the health systems agency, be reviewed, *in a timely matter* under an appeals mechanism consistent with State law governing the practices and procedures of administrative agencies, by an agency of the State (other than the State health planning and development agency) designated by the Governor, and

(B) the decision of the reviewing agency shall for purposes of this title and title XVI be considered the decision of the State health planning and development agency.

(14) Provides that any person who is adversely affected by a final decision of the State Agency pursuant to paragraph (4), (5), or (6) of section 1523(a) may, within a reasonable period of time after such a decision is made and any review is made pursuant to paragraph (13), obtain judicial review of such a decision in an appropriate State court. Upon such judicial review, the decision of the State Agency shall be affirmed unless it is arbitrary or capricious, or was made not in conformity with the applicable law.

(c) The Secretary shall approve any State Program and any modification thereof which complies with subsections (a) and (b). The Secretary shall review for compliance with the requirements of this part the specifications of and operations under each State Program approved by him. Such review shall be conducted not less often than [once each year.] *once every three years.*

STATE HEALTH PLANNING AND DEVELOPMENT FUNCTIONS

SEC. 1523. (a)* Each State Agency of a State designated under section 1521(b)(3) shall, except as authorized under subsection (b), perform within the State the following functions:

(1) Conduct the health planning activities of the State and implement those parts of the State health plan (under section 1524(c)(2)) and the plans of the health systems agencies within the State which relate to the government of the State.

[(2) Prepare and review and revise as necessary (but at least annually) a preliminary State health plan which shall be made up of the HSP's of the health systems agencies within the State. Such preliminary plan may, as found necessary by the State Agency, contain such revisions of such HSP's to achieve their appropriate coordination or to deal more effectively with statewide health needs. Such preliminary plan shall be submitted to the Statewide Health Coordinating Council of the State for approval or disapproval and for use in developing the State health plan referred to in section 1524(c).]

*Section 1523(a) amendments effective date is one year after enactment.

(2) Prepare and review and revise as necessary (but at least annually) a preliminary State health plan which shall be made up of the HSP's of the health systems agencies within the State. The State Agency shall refer the alcohol abuse, drug abuse, and mental health components of such HSP's to the State alcoholism, drug abuse, and mental health authorities, respectively, designated by the Governor, to review their respective components and to prepare the alcohol abuse, drug abuse, and the mental health components of the preliminary State health plan. The alcohol abuse, drug abuse, and mental health components of such preliminary plan may, as found necessary by such State authorities, contain such revisions of the alcohol abuse, drug abuse, and mental health components of such HSP's to achieve their appropriate coordination or to deal more effectively with statewide alcohol abuse, drug abuse, and mental health needs. The remainder of such preliminary plan may, as found necessary by the State Agency, contain such revisions of such HSP's to achieve their appropriate coordination or to deal more effectively with statewide needs. The preliminary State health plan shall be submitted to the Statewide Health Coordinating Council of the State for approval or disapproval and for use in developing the State health plan referred to in section 1524(c).

(3) Assist the Statewide Health Coordinating Council of the State in the review of the State medical facilities plan required under section 1603, and in the performance of its functions generally.

(4)(A) Serve as the designated planning agency of the State for the purposes of section 1122 of the Social Security Act if the State has made an agreement pursuant to such section, and (B) administer a State certificate of need program which applies to new institutional health services proposed to be offered or developed within the State and [which is satisfactory to the Secretary.] *which is consistent with standards established by the Secretary by regulation.* Such program shall provide for review and determination of need prior to the time such [services, facilities, and organizations] *services and facilities* are offered or developed or substantial expenditures are undertaken in preparation for such offering or development, and provide that only those [services, facilities, and organizations] *services and facilities* found to be needed *and that are consistent except in emergency circumstances that pose a threat to public health with the State health plan required by section 1524(c)* shall be offered or developed in the State. *In addition, such program shall provide (i) for procedures and penalties to enforce the provisions of the program and (ii) that after a certificate of need is issued a periodic review (at least every twenty-four months) shall be conducted of the progress being made in making the service or facility for which the certificate was issued available for use, and if it is determined, after notice and an opportunity for a hearing on the record, that substantial progress (absent unforeseen and unavoidable circumstances) is not being made, the certificate shall be withdrawn. In addition, each certificate of need in the State that is issued must*

be based solely on the record established in administrative and judicial proceedings (as provided for in this title) held with respect to an application for such certificate in order for such certificate of need program to be in compliance with this paragraph. No such program shall have provisions for the review and determination of need of the services, facilities, equipment, and organization of health maintenance organizations that are in addition to provisions for the review and determination of need of the services, facilities, equipment, and organization of other providers of ambulatory health care. In performing its functions under this paragraph the State Agency shall consider recommendations made by health systems agencies under section 1513(f).

(5) After consideration of recommendations submitted by health systems agencies under section 1413(f) respecting new institutional health services proposed to be offered within the State, make findings as to the need for such services [.], *except that this function shall not be performed if the State has in effect a certificate of need program as required by paragraph (4).*

(6) Review on a periodic basis (but not less often than every five years) all institutional health services being offered in the State and, after consideration of recommendations submitted by health systems agencies under section 1513(g) respecting the appropriateness of such services, make public its findings.

(7) *Provide technical assistance in obtaining and filling out the the necessary forms to individuals and public and private entities for the development of projects and programs.*

(b)(1) Any function described in subsection (a) may be performed by another agency of the State government upon request of the Governor under an agreement with the State Agency satisfactory to the Secretary.

(2) The requirement of paragraph (4)(B) of subsection (a) shall not apply to a State Agency of a State until the expiration of the first regular session of the legislature of such State which begins after the date of enactment of this title.

(3) A State Agency shall complete its findings with respect to the appropriateness of any existing institutional health service within one year after the date a health systems agency has made its recommendation under section 1513(g) with respect to the appropriateness of the service.

(c) If a State Agency makes a decision in carrying out a function described in paragraph (4), (5), or (6) of subsection (a) which is not consistent with the goals of the applicable HSP or the priorities of the applicable AIP, the State Agency shall submit to the appropriate health systems agency a detailed statement of the reasons for the inconsistency.

STATEWIDE HEALTH COORDINATING COUNCIL

SEC. 1524. (a) A State health planning and development agency designated under section 1521 shall be advised by a Statewide Health Coordinating Council (hereinafter in this section referred to as the "SHCC") which (1) is organized in the manner described by subsection (b), and (2) performs the functions listed in subsection (c).

(b)*(1) A SHCC of a State shall be composed in the following manner:

(A) (i) A SHCC shall have no fewer than sixteen representatives appointed by the Governor of the State from lists of at least five nominees submitted to the Governor by each of the health systems agencies designated for health service areas which fall, in whole or in part, within the State.

(ii) Each such health systems agency shall be entitled to the same number of representatives on the SHCC.

(iii) Each such health systems agency shall be entitled to at least two representatives on the SHCC. Of the representatives of a health systems agency, not less than one-half shall be individuals who are [consumers of health care] *consumers of health care or mental health care* and who are not [providers of health care.] *providers of health care or mental health care.*

(B) In addition to the appointments made under subparagraph (A), the Governor of the State may appoint such persons (including State officials, public elected officials, and other representatives of governmental authorities within the State) to serve on the SHCC as he deems appropriate; except that (i) the number of persons appointed to the SHCC under this subparagraph may not exceed 40 per centum of the total membership of the SHCC, and (ii) a majority of the persons appointed by the Governor shall be [consumers of health care] *consumers of health care or mental health care* who are not also [providers of health care.] *providers of health care or mental health care.*

(C) Not less than one-third of the [providers of health care] *providers of health care or mental health care* who are members of a SHCC shall be direct [providers of health care] *providers of health care or mental health care* (as described in section 1531(3)).

(D) Where [two] *one* or more hospitals or other health care facilities of the Veterans' Administration are located in a State, the SHCC shall, in addition to the appointed members, include, as an ex officio member, an individual whom the Chief Medical Director of the Veterans' Administration shall have designated as a representative of such facilities.

(E) Members of the SHCC who are not consumers of health or mental health care and who are not providers of health or mental health care must include individuals who are members of rural and urban medically underserved populations, if such populations exist in the State.

(2) The SHCC shall select from among its members a chairman.

(3) The SHCC shall conduct all of its business meetings in public, and shall meet at least once in each calendar quarter of a year.

(4) A SHCC shall adopt procedures in accordance with regulations promulgated by the Secretary to insure that no member, employee, consultant or agent participates in any matter regarding any person, institution, organization or other entity with which he or she has or has had within the past three years any substantial direct or indirect

*Section 1524 (b) and (c) amendments' effective date is one year after enactment.

employment, fiduciary, competitive, medical staff, or ownership or other financial interest.

(c) A SHCC shall perform the following functions:

(1) [Review annually] *Establish (in consultation with the health systems agencies within the State and the State agency) a uniform format for HSP's and AIP's and review annually and* coordinate the HSP and AIP of each health systems agency within the State and report to the Secretary, for purposes of his review under section 1535(c), its comments on such HSP and AIP.

(2)(A) [Prepare] *with the concurrence or the Governor, prepare* and review and revise as necessary (but at least annually) a State health plan which shall be made up of the HSP's of the health systems agencies within the State. Such plan may, as found necessary by the SHCC, contain revisions of such HSP's to achieve their appropriate coordination or to deal more effectively with statewide health needs. Each health systems agency which participates in the SHCC shall make available to the SHCC its HSP for each year for integration into the State health plan and shall, as required by the SHCC, revise its HSP to achieve appropriate coordination with the HSP's of the other agencies which participate in the SHCC or to deal more effectively with statewide health needs.

(B) In addition to the requirements of subparagraph (A), a State health plan shall be coordinated with the State mental health plan developed pursuant to the Community Mental Health Centers Act, the State alcohol abuse plan developed pursuant to the Comprehensive Alcohol Abuse and Alcoholism Prevention Treatment and Rehabilitation Act, and the State drug abuse plan developed pursuant to the Drug Abuse Office and Treatment Act of 1972, and shall describe the resource requirements of manpower, facilities, equipment, and funds necessary to provide access, availability and quality services at reasonable cost to persons receiving care within the State including, at a minimum—

(i) the institutional health services (as defined in section 1531(5)) comprising, but not limited to, the number and type of medical facilities, rehabilitation facilities, nursing homes, beds, and equipment needed for acute inpatient, psychiatric inpatient, obstetrical inpatient, neonatal inpatient, long term care, and treatment for alcohol abuse and drug abuse; the extent to which existing medical facilities, rehabilitation facilities nursing homes, beds and equipment are in need of modernization or conversion to new uses: and, the extent to which new such medical facilities, nursing homes, beds, and equipment need to be constructed or acquired, and

(ii) other health services (other than institutional health services as defined in section 1531(5)) comprising, but not limited to, the number and type of health maintenance organizations, outpatient (including primary care), rehabilitation facilities, facilities for the treatment of alcohol abuse and drug abuse, and other medical facilities, home health agencies and equipment needed for public health services and outpatient care and the extent to which such outpatient and other

facilities and equipment are in need of modernization and conversion to new uses and the extent to which new such health maintenance organizations, outpatient and other facilities, home health agencies and equipment need to be constructed or acquired.

[(B)] (*C*) In the preparation and revision of the State health plan, the SHCC shall review and consider the preliminary State health plan submitted by the State agency under section 1523(a)(2), and shall conduct a public hearing on the plan as proposed and shall give interested persons an opportunity to submit their views orally and in writing. Not less than thirty days prior to any such hearing, the SHCC shall publish in at least two newspapers of general circulation in the State a notice of its consideration of the proposed plan, the time and place of the hearing, the place at which interested persons may consult the plan in advance of the hearing, and the place and period during which to direct written comment to the SHCC on the plan.

(*D*) *If a State health plan as required by this subsection is not in effect for the State, the Secretary may not make any grant to the State health planning development agency pursuant to section 1525.*"

(3) Review annually the budget of each such health systems agency and report to the Secretary, for purposes of his review under section 1535(a), its comments on such budget.

(4) Review applications submitted by such health systems agencies for grants under sections 1516 and 1640 and report to the Secretary its comments on such applications.

(5) Advise the State Agency of the State generally on the performance of its functions.

(6) Review annually and approve or disapprove any State plan and any application (and any revision of a State plan or application) submitted to the Secretary as a condition to the receipt of any funds under allotments made to States under this Act, the Community Mental Health Centers Act, *sections 409 and 410 of the Drug Abuse Office and Treatment Act*, or the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970. Notwithstanding any other provision of this Act or any other Act referred to in the preceding sentence, the Secretary shall allow a SHCC sixty days to make the review required by such sentence. If a SHCC disapproves such a State plan or application, the Secretary may not make Federal funds available under such State plan or application until he has made, upon request of the Governor of the State which submitted such plan or application or another agency of such State, a review of the SHCC decision. If after such review the Secretary decides to make such funds available, the decision by the Secretary to make such funds available shall be submitted to the SHCC and shall contain a detailed statement of the reasons for the decision.

(*d*) *No individual who, as a member, employee, consultant or agent of a SHCC shall, by reason of his performance of any duty, function*

or activity required of, or authorized to be undertaken by the SHCC, be liable for payment of damages under any law of the United States or any State (or political subdivision thereof) if he could have reasonably believed he was acting within the scope of such duty, function, or activity, and acted, with respect to that performance, without gross negligence or malice toward any person affected by it.

GRANTS FOR STATE HEALTH PLANNING AND DEVELOPMENT

SEC. 1525.(a) The Secretary shall make grants to State health planning and development agencies designated under subsection (b)(2) or (b)(3) of section 1521 to assist them in meeting the costs of their operation. Any grant made under this subsection to a State Agency shall be available for obligation only for a period not to exceed the period for which its designation agreement is entered into or [renewed] *in the event that the grant is renewed, may be carried forward to the subsequent grant period without being deducted from the subsequent grant award.* The amount of any grant made under this subsection shall be determined by the Secretary, except that no grant to a designated State Agency may exceed 75 percentum of its operation costs (as determined under regulations of the Secretary) during the period for which the grant is available for obligation.

(b) Grants under subsection (a) shall be made on such terms and conditions as the Secretary may prescribe; except that the Secretary may not make a grant to a State Agency unless he receives satisfactory assurances that the State Agency will expend in performing the functions prescribed by section 1523 during the fiscal year for which the grant is sought an amount of funds from non-Federal sources which is at least as great as the average amount of funds expended, in the three years immediately preceding the fiscal year for which such grant is sought, by the State, for which such State Agency has been designated, for the purposes for which funds under such grant may be used (excluding expenditures of a nonrecurring nature).

(c) For the purpose of making payments under grants under subsection (a), there are authorized to be appropriated $25,000,000 for the fiscal year ending June 30, 1975, $30,000,000 for the fiscal year ending June 30, 1976, [and] $35,000,000 each for the fiscal years ending September 30, 1977, and September 30, 1978. *$40,000,000 for the fiscal year ending September 30, 1979, $45,000,000 for the fiscal year ending September 30, 1980, and $50,000,000 for the fiscal year ending September 30, 1981.*

GRANTS FOR RATE REGULATION

SEC. 1526. (a) For the purpose of demonstrating the effectiveness of State Agencies regulating rates for the provision of health care, the Secretary may make grants to a State Agency designated, under an agreement entered into under section 1521(b)(3), for a State which (in accordance with regulations prescribed by the Secretary) has indicated an intent to regulate (not later than six months after the date of the enactment of this title) rates for the provision of health care within the State. Not more than six State Agencies may receive grants under this subsection.

(b) (1) A State Agency which receives a grant under subsection (a) shall—

(A) provide the Secretary satisfactory evidence that the State Agency has under State law the authority to carry out rate regulation functions in accordance with this section and provide the Secretary a current budget for the performance of such functions by it;

(B) set forth in such detail as the Secretary may prescribe the qualifications for personnel having responsibility in the performance of such functions, and shall have a professional staff for rate regulation, which staff shall be headed by a Director;

(C) provide for such methods of administration as found by the Secretary to be necessary for the proper and efficient administration of such functions;

(D) perform its functions in accordance with procedures established and published by it, which procedures shall conform to the requirements of section 1532;

(E) comply with the requirements prescribed by paragraphs (6) through (12) of section 1522(b) with respect to the functions prescribed by subsection (a);

(F) provide for the establishment of a procedure under which the State Agency will obtain the recommendation of the appropriate health systems agency prior to conducting a review of the rates charged or proposed to be charged for services; and

(G) meet such other requirements as the Secretary may prescribe.

(2) In prescribing requirements under paragraph (1) of this subsection, the Secretary shall consider the manner in which a State Agency shall perform its functions under a grant under subsection (a), including whether the State Agency should—

(A) permit those engaged in the delivery of health services to retain savings accruing to them from effective management and cost control,

(B) create incentives at each point in the delivery of health services for utilization of the most economical modes of services feasible,

(C) document the need for and cost implications of each new service for which a determination of reimbursement rates is sought, and

(D) employ for each type or class of person engaged in the delivery of health services—

(i) a unit for determining the reimbursement rates, and

(ii) a base for determining rates of change in the reimbursement rates,

which unit and base are satisfactory to the Secretary.

(c) Grants under subsection (a) shall be made on such terms and conditions as the Secretary may prescribe, except that (1) such a grant shall be available for obligation only during the one-year period beginning on the date such grant was made, *except that if such a grant is renewed, funds may be carried forward to the subsequent grant period without being deducted from the subsequent grant award* and (2) no State Agency may receive more than three grants under subsection (a).

(d) Each State Agency which receives a grant under subsection (a) shall report to the Secretary (in such form and manner as he shall

prescribe) on the effectiveness of the rate regulation program assisted by such grant. The Secretary shall report annually to the Congress on the effectiveness of the programs assisted by the grants authorized by subsection (a).

(e) There are authorized to be appropriated to make payments under grants under subsection (a) $4,000,000 for the fiscal year ending June 30, 1975, $5,000,000 for the fiscal year ending June 30, 1976, and $6,000,000 each for the fiscal years ending September 30, 1977 [and] September 30, 1978, *$6,000,000 for the fiscal year ending September 30, 1979, $7,000,000 for the fiscal year ending September 30, 1980, and $7,000,000 for the fiscal year ending September 30, 1981.*

Part D—General Provisions

DEFINITIONS

Sec. 1531. For purposes of this title:

(1) The term "State" includes the District of Columbia and the Commonwealth of Puerto Rico.

(2) The term "Governor" means the chief executive officer of a State or his designee.

(3) The term [provider of health care"] *provider of health or mental care*" means an individual—

(A) who is a direct provider of health care (including a physician (*a doctor of medicine and a doctor of osteopathy*), dentist, nurse, prodiatrist, optometrist, or physician assistant) in that individual's primary current activity is the provision of health care to individuals or the administration of facilities or institutions (including hospitals, long-term care facilities, substance abuse treatment facilities, outpatient facilities, *rehabilitation facilities* and health maintenance organizations) in which such care is provided and, when required by State law, the individual has received professional training in the provision of such care or in such administration and is licensed or certified for such provision or administration; or

(B) who is an indirect provider of health care in that the individual—

(i) holds a fiduciary position with, or has a fiduciary interest in, any entity described in subclause (II) or (IV) of clause (ii); *except that an individual shall not be considered an indirect provider of health care solely because he is a member of a governing board of an entity described in subclause (II) or (IV) of clause (ii);*

(ii) receives (either directly or through his spouse) more than one-tenth of his gross annual income from any one or combination of the following:

(I) Fees or other compensation for research into or instruction in the provision of health care.

(II) Entities engaged in the provision of health care or in such research or instruction.

(III) Producing or supplying drugs or other articles for individuals or entities for use in the provision of or

in research into or instruction in the provision of health care.

(IV) Entities engaged in producing drugs or such other articles.

(iii) is a member of the immediate family of an individual described in subparagraph (A) or in clause (i), (ii), or (iv) of subparagraph (B); or

(iv) is engaged in issuing any policy or contract of individual or group health insurance or hospital or medical service benefits.

(4) The term "health resources' includes health services, health professions personnel, and health facilities, except that such term does not include Christian Science sanatoriums operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts.

(5)(A) The term 'institutional health services' means (i) the health services provided through health care facilities (but excluding health care facilities of health maintenance organizations other than hospitals) as defined in regulations of the Secretary including, but not limited to, private and public hospitals, rehabilitation facilities, and nursing homes if such services entail annual operating costs of $50,000 or more; and (ii) diagnostic or therapeutic equipment, acquired through purchase, rental, lease, or gift, valued at the time of acquisition in excess of $150,000, used in the delivery of health care services by any person, institution, or other entity.

(B) In determining whether diagnostic or therapeutic equipment has a value in excess of $150,000 for purposes of subparagraph (A), the value of studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition of such equipment shall be included.

[(5) The term "institutional health services" means the health services provided through health care facilities and health maintenance organizations (as such facilities and organizations are defined in regulations prescribed under section 1122 of the Social Security Act) and includes the entities through which such services are provided.]

(6)(a) Except as provided in paragraph (b), the term 'health maintenance organization' means an entity which has had approved an application for assistance under section 1304 or a public or private organization, organized under the laws of any State, which (1) provides or otherwise makes available to enrolled participants health care services, including at least the following basic health care services: usual physician services, hospitalization laboratory, X-ray, emergency and preventive services, and out of area coverage; (2) is compensated (except for copayments) for the provision of the basic health care services listed in paragraph (1) to enrolled participants on a predetermined periodic rate basis; and (3) provides physicians' services primarily (i) directly through physicians who are either employees or partners of such organization, or (ii) through arrangements with individual physicians or one or more groups of physicians (organized on a group practice or individual practice basis).

(b) For the purposes of section 1532(d), the term health maintenance organization" means an entity which has been determined by the

Secretary to be a qualified health maintenance organization pursuant to section 1310(d).

(7) The term "medical underserved population" has the same meaning as such term has under section 330(b)(3)."

(8) The term "rehabilitation facility" means a facility which is operated for the primary purpose of providing rehabilitation services to handicapped individuals, and which provides singly or in combination one or more of the following services for handicapped individuals: (A) rehabilitation services which shall include, under one management, medical, psychological, social and vocational services, (B) testing, fitting, or training in the use of prosthetic and orthotic devices, (C) prevocational conditioning or recreational therapy, (D) physical and occupational therapy, (E) speech and hearing therapy, (F) psychological and social services, (G) evaluation of rehabilitation potential, (H) personal and work adjustments, (I) vocational training with a view toward career advancement (in combination with other rehabilitation services), (J) evaluation or control of specific disabilities, (K) orientation and mobility services to the blind, and (L) extended employment for those handicapped individuals who cannot be readily absorbed in the competitive labor market, except that all medical and related health services must be described by, or under the formal supervision of, persons licensed to prescribe or supervise the provision of such services in the State.

PROCEDURES AND CRITERIA FOR REVIEWS OF PROPOSED HEALTH SYSTEM CHANGES

SEC. 1532. (a) In conducting reviews pursuant to subsections [(e), (f), and (g),] *(e), (f), (g), and (h)* of section 1513 or in conducting any other reviews of proposed or existing health services, each health systems agency shall (except to the extent approved by the Secretary) follow procedures, and apply criteria, developed and published by the agency in accordance with regulations of the Secretary; and in performing its review functions under section 1523, a State Agency shall (except to the extent approved by the Secretary) follow procedures and apply criteria, developed and published by the State Agency in accordance with regulations of the Secretary. Procedures and criteria for reviews by health systems agencies and State Agencies may vary according to the purpose for which a particular review is being conducted or the type of health services being reviewed. *Procedures and criteria for reviews by health systems agencies pursuant to section 1513(f) and reviews by State Agencies pursuant to paragraphs (4) and (5) of section 1523(a) must provide that applications be submitted in accordance with timetables established by such agencies; that such reviews be undertaken in a timely fashion; and that completed applications pertaining to similar types of services or facilities affecting the same service area are considered in relation to each other at appropriate times (but no less often than twice a year). Procedures and criteria for reviews by health systems agencies pursuant to section 1513(g) and by State Agencies pursuant to section 1523(a)(6) must provide that reviews of similar types of institutional health services affecting the same service area be considered in relation to each other.*

Health systems agencies and State Agencies within a State shall cooperate in the development of procedures and criteria under this subsection to the extent appropriate to the achievement of efficiency in their reviews and consistency in criteria for such reviews.

(b) Each health systems agency and State Agency shall include in the procedures required by subsection (a) at least the following:

(1) [Written] *Timely written* notification to affected persons *and to all other persons who have asked to have their names placed on a mailing list maintained by the Agency of the beginning of a review.*

(2) Schedules for reviews which provide that no review shall, to the extent practicable, take longer than ninety days from the date the notification described in paragraph (1) is made.

(3) Provision for persons subject to a review to submit to the agency or State Agency (in such form and manner as the agency or State Agency shall prescribe and publish) such information as the agency or State Agency may require concerning the subject of such review.

(4) Submission of applications (subject to review by a health systems agency or a State Agency) made under this Act or other provisions of law for Federal financial assistance for health services to the health systems agency or State Agency at such time and in such manner as it may require.

(5) Submission of periodic reports by providers of health services and other persons subject to agency or State Agency review respecting the development of proposals subject to review.

(6) Provision for written findings which state the basis for any final decision or recommendation made by the agency or State Agency.

(7) [Notification] *Timely notification* of providers of health services and other persons subject to agency or State Agency review of the status of the agency or State Agency review of the health services or proposals subject to review, fundings made in the course of such review, and other appropriate information respecting such review.*

(8) Provision for public hearings in the course of agency or State Agency review prior to any decision if requested by persons directly affected by the review; and provision for public hearings, for good cause shown, respecting agency and State Agency decisions.

(9) Preparation and publication of regular reports by the agency and State Agency of the reviews being conducted (including a statement concerning the status of each such review) and of the reviews completed by the agency and State Agency (including a general statement of the findings and decisions made in the course of such reviews) since the publication of the last such report.

(10) Access by the general public to all applications reviewed by the agency and State Agency and to all other written materials

*Section 1532(b)(7) and Section 1532(c) amendments effective date is six months after enactment.

pertinent to any agency or State Agency review, *except to personnel records and data regarding an individual employee the disclosure of which would constitute a clearly unwarranted invasion of the personal privacy of such employee.*

(11) In the case of construction projects, submission to the agency and State Agency by the entities proposing the projects of letters of intent in such details as may be necessary to inform the agency and State Agency of the scope and nature of the projects at the earliest possible opportunity in the course of planning of such construction projects.

(12) In the case of reviews pursuant to subsections (f) and (g) of section 1513 and subsections (4), (5), and (6) of section 1523, and where appropriate for other reviews—

(A) opportunity for each participant to present evidence and arguments orally and/or by written submission,

(B) opportunity for each participant to cross examine any other participant who makes a factual allegation relevant to such a review,

(C) maintenance of a record of the hearing,

(D) provision that the decision of the agency and Agency be based solely on the record of the hearing, and

(E) prohibition on ex parte contacts with individuals voting on the review process.

(c) Criteria required by subsection (a) for health systems agency and State Agency review shall include consideration of at least the following:

(1) The relationship of the health services being reviewed to the applicable HSP and AIP.

(2) The relationship of services reviewed to the long-range development plan (if any) of the person providing or proposing such services.

(3) The need that the population served or to be served by such services has for such services.

(4) The availability of alternatives, less costly, or more effective methods of providing such services.

(5) The relationship of services reviewed to the existing health care system of the area in which such services are provided or proposed to be provided.

(6) In the case of health services proposed to be provided, the availability of resources (including health manpower, management personnel, and funds for capital and operating needs) for the provision of such services and the availability of alternative uses of such resources for the provision of other health services.

(7) The special needs and circumstances of those entities which provide a substantial portion of their services or resources, or both, to individuals not residing in the health service areas in which the entities are located or adjacent health service areas. Such entities may include medical and other health professions schools, multidisciplinary clinics, specialty centers, and such other entities as the Secretary may by regulation prescribe.

(8) The special needs and circumstances of health maintenance organizations for which assistance may be provided under title XIII.

(9) In the case of a construction project—

(A) the costs and methods of the proposed construction, and

(B) the probable impact of the construction project reviewed on the costs of providing health services by the person proposing such construction project [.] *and on the costs and charges to the public of providing health services by other persons.*

(10) In the case of existing services or facilities, the quality of care provided by such services or facilities in the past.

(11) The extent to which such proposed services will be accessible to all the residents of the area to be served by such services.".

(d) Notwithstanding subsection (c), an application 1531(6)(b) for a certificate of need for new institutional health services shall be approved by the State Agency if the State Agnecy finds (in accordance with criteria prescribed by the Secretary) that—

(1) approval of such application is required to meet the needs of the members of the health maintenance organization and of the new members which such organization can reasonably be expected to enroll, and

"(2) the health maintenance organization is unable to provide, through services or facilities which can reasonably be expected to be available to the organization, its institutional health services in a reasonable and cost-effective manner which is consistent with the basic method of operation of the organization and which makes such services available on a long-term basis through physicians and other health professionals associated with it.".

TECHNICAL ASSISTANCE FOR HEALTH SYSTEMS AGENCIES AND STATE HEALTH PLANNING AND DEVELOPMENT AGENCIES

SEC. 1533. (a) The Secretary shall provide (directly or through grants or contracts, or both) to designated health systems agencies and State Agencies (1) assistance in developing their health plans and approaches to planning various types of health services, (2) technical materials, including methodologies, policies, and standards appropriate for use in health planning, and (3) other technical assistance as may be necessary in order that such agencies may properly perform their functions.

(b) The Secretary shall include in the materials provided under subsection (a) the following:

(1)(A) Specification of the minimum data needed to determine the health status of the residents of a health service area and the determinants of such status.

(B) Specifications of the minimum data needed to determine the status of the health resources and services of a health service area.

(C) Specification of the minimum data needed to describe the use of health resources and services within a health services area.

(2) Planning approaches, methodologies, policies, and standards which shall be consistent with the guidelines established by the Secretary under section 1501 for appropriate planning and

development of health resources, and which shall cover the priorities listed in section 1502.

(3) Guidelines for the organization and operation of health systems agencies and State Agencies including guidelines for—

(A) the structure of a health systems agency, consistent with section 1512(b), and of a State Agency, consistent with section 1522;

* * * * *

(4) A classification system for health services institutions. Such classification system shall quantitatively describe and group health services institutions of the various types. Factors included in such classification system shall include—

(A) the number of beds operated by an institution;

(B) the geographic location of an institution;

(C) the operation of a postgraduate physician training program by an institution; and

(D) the complexity of services provided by an institution.

(5) A uniform system for the reporting by health services institutions of—

(A) the aggregate cost of operation and the aggregate volume of services, as calculated in accordance with the system established by the Secretary under paragraph (1);

(B) the cost and volume of services at various cost centers, and subcost centers, as calculated in accordance with the system established by the Secretary under paragraph (2); and

(C) rates, by category of patient and class of purchaser, as calculated in accordance with the system established by the Secretary under paragraph (3).

Such system shall provide for an appropriate application of such system in the different types of institutions (including hospitals, nursing homes, and other types of health services institutions) and different sizes of such institutions.

CENTERS FOR HEALTH PLANNING

SEC. 1534. (a)* For the purposes of assisting the Secretary in carrying out this title, providing such technical and consulting assistance as health systems agencies and State Agencies may from time to time require, conducting research, studies and analyses of health planning and resources development, and developing health planning approaches, methodologies, policies, and standards, the Secretary shall by grants [or contracts, or both,] assist public or private nonprofit entities in meeting the costs of planning and developing new centers, and operating existing and new centers, for multidisciplinary health planning development and assistance. To the extent practicable, the Secretary shall provide assistance under this section so that at least five such centers will be in operation by June 30, 1976.

(b)(1) No grant [or contract] may be made under this section for planning or developing a center unless the Secretary determines that when it is operational it will meet the requirements listed in para-

*Section 1534(a) amendment effective date is one year after enactment.

graph (2) *and be able to provide assistance and dissemination of information to health systems agencies and State Agencies as provided in subsections (a) and (c)* and no grant [or contract] may be made under this section for operation of a center unless the center meets such requirements *and is able to provide such assistance and dissemination of information.*

(2) The requirements referred to in paragraph (1) are as follows:

(A) There shall be a full-time director of the center who possesses a demonstrated capacity for substantial accomplishment and leadership in the field of health planning and resources development, and there shall be such additional professional staff as may be appropriate.

(B) The staff of the center shall represent a diversity of relevant disciplines.

(C) Such additional requirements as the Secretary may by regulation prescribe.

(c) Centers assisted under this section (1) may enter into arrangements with health systems agencies and State Agencies for the provision of such services as may be appropriate and necessary in assisting the agencies and State Agencies in performing their functions under section 1513 or 1523, respectively, and (*2*) *shall develop and use methods (satisfactory to the Secretary) to disseminate to such agencies and State Agencies planning approaches, methodologies (including methodologies to provide for education of new board members and new staff and continuing education of board members and staff of such agencies and State Agencies), policies, and standards.*

(d) For the purpose of making payments pursuant to grants [and contracts] under subsection (a) there are authorized to be appropriated $5,000,000 for the fiscal year ending June 30, 1975, $8,000,000 for the fiscal year ending June 30, 1976, [and] $10,000,000 each for the fiscal years ending September 30, 1977 and September 30, 1978, *$12,000,000 for the fiscal year ending September 30, 1979, $15,000,000 for the fiscal year ending September 30, 1980, and $18,000,000 for the fiscal year ending September 30, 1981.*

REVIEW BY THE SECRETARY

SEC. 1535. (a) The Secretary shall review and approve or disapprove the annual budget of each designated health systems agency and State Agency. In making such review and approval or disapproval the Secretary shall consider the comments of Statewide Health Coordinating Councils submitted under section 1524(c)(3). Information sumitted to the Secretary by a health systems agency or a State Agency in connection with the Secretary's review under this subsection shall be made available by the Secretary, upon request, to the appropriate committees (and their subcommittees) of the Congress.

(b) The Secretary shall prescribe performance standards covering the structure, operation, and performance of the functions of each designated health systems agency and State Agency, and he shall establish a reporting system based on the performance standards that allows for continuous review of the structure, operation, and performance of the functions of such agencies.

(c) The Secretary shall review in detail at least every three years the structure, operation, and performance of the functions of each designated health systems agency to determine—

(1) the adequacy of the HSP of the agency for meeting the needs of the residents of the area for a healthful environment and for accessible, acceptable and continuous quality health care at reasonable costs, and the effectiveness of the AIP in achieving the system described in the HSP;

(2) if the structure, operation, and performance of the functions of the agency meet the requirements of sections 1512(b) and 1513;

(3) the extent to which the agency's governing body (and executive committee (if any)) represents the residents of the health service area for which the agency is designated;

(4) the professional credentials and competence of the staff of the agency;

(5) the appropriateness of the data assembled pursuant to section 1513(b)(1) and the quality of the analyses of such data;

(6) the extent to which technical and financial assistance from the agency have been utilized in an effective manner to achieve goals and objectives of the HSP and the AIP; and

(7) the extent to which it may be demonstrated that—

(A) the health of the residents in the agency's health service area has been improved;

(B) the accessibility, acceptability, continuity, and quality of health care in such area has been improved; and

(C) increases in costs of the provision of health care have been restrained.

(e) *In making the reviews required by subsections (c) and (d), the Secretary shall consider the comments submitted by any interested person.*

SPECIAL PROVISIONS FOR CERTAIN STATES AND TERRITORIES

SEC. 1536. (a) Any State which—

(1) has no county or municipal public health institution or department, and

(2) has, prior to the date of enactment of this title, maintained a health planning system which substantially complies with the purposes of this title,

and the Virgin Islands, Guam, the Trust Territory of the Pacific Islands, the Northern Mariana Islands and American Samoa shall each be considered in accordance with subsection (b) to be a State for purposes of this title.

(b) In the case of an entity which under subsection (a) is to be considered a State for purposes of this title—

(1) no health service area shall be established within it,

(2) no health systems agency shall be designated for it,

(3) the State Agency designated for it under section 1521 [may] *shall*, in addition to the functions prescribed by section 1523, perform the functions prescribed by section 1513 and shall be eligible to receive grants authorized by sections 1516 and 1640, *provided that nothing contained herein shall prevent such State*

Agency from contracting with an entity described in Section 1512(b)(1) for performance of a part of such functions or participation in the performance of such functions, and

(4) the chief executive officer shall appoint the Statewide Health Coordinating Council prescribed by section 1524 in accordance with regulations of the Secretary.

TITLE XVI—HEALTH RESOURCES DEVELOPMENT

PART A—PURPOSE, STATE PLAN, AND PROJECT APPROVAL

PURPOSE

SEC. 1601. It is the purpose of this title to provide assistance, through allotments under part B and loans and loan guarantees and interest subsidies under part C, for projects for—

(1) modernization of medical facilities;

(2) construction of new outpatient medical facilities;

(3) construction of new inpatient medical facilities in areas which have experienced (as determined under regulations of the Secretary) recent rapid population growth; and

(4) conversion of existing medical facilities for the provision of new health services,

and to provide assistance, through grants under part D, for construction and modernization projects designed to prevent or eliminate safety hazards in medical facilities or to avoid noncompliance by such facilities with licensure or accreditation standards.

GENERAL REGULATIONS

SEC. 1602. The Secretary shall by regulation—

(1) prescribe the general manner in which the State Agency of each State shall determine for the State medical facilities plan under section 1603 the priority among projects within the State for which assistance is available under this title, based on the relative need of different areas within the State for such projects and giving special consideration—

(A) to projects for medical facilities serving areas with relatively small financial resources and for medical facilities serving rural communities,

(B) in the case of projects for modernization of medical facilities, to projects for facilities serving densely populated areas,

(C) in the case of projects for construction of outpatient medical facilities, to projects that will be located in, and provide services for residents of, areas determined by the Secretary to be rural or urban poverty areas,

(D) to projects designed to (i) eliminate or prevent imminent safety hazards as defined by Federal, State, or local fire, building, or life safety codes or regulations, or (ii) avoid non-compliance with State or voluntary licensure or accreditation standards, and

(E) to projects for medical facilities which, alone or in conjunction with other facilities, will provide comprehensive health care, including outpatient and preventive care as well as hospitalization;

(2) prescribed for medical facilities projects assisted under this title general standards of construction, modernization, and equipment for medical facilities of different classes and in different types of location;

(3) prescribed criteria for determining needs for medical facility beds and needs for medical facilities, and for developing plans for the distribution of such beds and facilities;

(4) prescribe criteria for determining the extent to which existing medical facilities are in need of modernization;

(5) require each State medical facilities plan under section 1603 to provide for adequate medical facilities for all persons residing in the State and adequate facilities to furnish needed health services for persons unable to pay therefor; and

(6) prescribe the general manner in which each entity which receives financial assistance under this title or has received financial assistance under this title or title VI shall be required to comply with the assurances required to be made at the time such assistance was received and the means by which such entity shall be required to demonstrate compliance with such assurances.

An entity subject to the requirements prescribed pursuant to paragraph (6) respecting compliance with assurances made in connection with receipt of financial assistance shall submit periodically to the Secretary data and information which reasonably support the entity's compliance with such assurances. The Secretary may not waive the requirement of the preceding sentence.

STATE MEDICAL FACILITIES PLAN

SEC. 1603. (a) Before an application for assistance under this title (other than part D) for a medical facility project, described in section 1601 may be approved, the State Agency of the State in which such project is located must have submitted to the Secretary and had approved by him a State medical facilities plan. To be approved by the Secretary a State medical facilities plan for a State must—

(1) prescribe that the State Agency of the State shall administer or supervise the administration of the plan and contain evidence satisfactory to the Secretary that the State Agency has the authority to carry out the plan in conformity with this title;

(2) prescribe that the Statewide Health Coordinating Council of the State shall advise and consult with the State Agency in carrying out the plan;

(3) be approved by the Statewide Health Coordinating Council *and the Governor of the State* as consistent with the State health plan developed pursuant to section 1524(c)(2):

(4) set forth, in accordance with criteria established in regulations prescribed under section 1602 and on the basis of a statewide inventory of existing medical facilities, a survey of need, and the plans of health systems agencies within the State—

(A) the number and type of medical facility beds and medical facilities needed to provide adequate inpatient care to people residing in the State, and a plan for the distribution of such beds and facilities in health services areas throughout the State,

(B) the number and type of outpatient and other medical facilities needed to provide adequate public health services and outpatient care to people residing in the State, and a plan for the distribution of such facilities in health service areas throughout the State, and

(C) the extent to which existing medical facilities in the State are in need of modernization or conversion to new uses;

(5) set forth a program for the State for assistance under this title for projects described in section 1601, which program shall indicate the type of assistance which shall be made available to each project and shall conform to the assessment of need set forth pursuant to paragraph (4) and regulations promulgated under section 1602;

(6) set forth (in accordance with regulations promulgated under section 1602) priorities for the provision of assistance under this title for projects in the program set forth pursuant to paragraph (5);

(7) provide minimum requirements (to be fixed in the discretion of the State Agency) for the maintenance and operation of facilities which receive assistance under this title, and provide for enforcement of such requirements;

(8) provide for affording to every applicant for assistance for a medical facilities project under this title an opportunity for a hearing before the State Agency; and

(9) provide that the State Agency will from time to time, but not less often than annually, review the plan and submit to the Secretary any modifications thereof which it considers necessary.

(b) The Secretary shall approve any State medical facilities plan and any modification thereof which complies with the provisions of subsection (a) if the State Agency, as determined under the review made under section 1535(d), is organized and operated in the manner prescribed by section 1522 and is carrying out its functions under section 1523 in a manner satisfactory to the Secretary. If any such plan or modification thereof shall have been disapproved by the Secretary for failure to comply with subsection (a), the Secretary shall, upon request of the State Agency, afford it an opportunity for hearing.

APPROVAL OF PROJECTS

SEC. 1604. (a) For each project described in section 1601 and included within a State's State medical facilities plan approved under section 1603 there shall be submitted to the Secretary, through the State's State Agency, an application. An application for a grant under section 1625 shall be submitted directly to the Secretary. Except as provided in section 1625, the applicant under such an application may be a State, a political subdivision of a State or any other public entity, or a private nonprofit entity. If two or more entities join in a project,

an application for such project may be filed by any of such entities or by all of them.

(b) (1) Except as authorized under paragraph (2), an application for any project shall set forth—

(A) in the case of a modernization project for a medical facility for continuation of existing health services, a finding by the State Agency of a continued need for such services, and, in the case of any other project for a medical facility, a finding by the State Agency of the need for the new health services to be provided through the medical facility upon completion of the project;

(B) a description of the site of such project;

(C) plans and specifications therefor which meet the requirements of the regulations prescribed under section 1602;

(D) reasonable assurance that title to such site is or will be vested in one or more of the entities filing the application or in a public or other nonprofit entity which is to operate the facility on completion of the project;

(E) reasonable assurance that adequate financial support will be available for the completion of the project and for its maintenance and operation when completed, and, for the purpose of determining if the requirements of this subparagraph are met, Federal assistance provided directly to a medical facility which is located in an area determined by the Secretary to be an urban or rural poverty area or through benefits provided individuals served at such facility shall be considered as financial support;

(F) the type of assistance being sought under this title for the project;

(G) except in the case of a project under section 1625, a certification by the State Agency of the Federal share for the project;

(H) reasonable assurance that all laborers and mechanics employed by contractors or subcontractors in the performance of work on a project will be paid wages at rates not less than those prevailing on similar construction in the locality as determined by the Secretary of Labor in accordance with the Act of March 3, 1931 (40 U.S.C. 276a—276a–5, known as the Davis-Bacon Act), and the Secretary of Labor shall have with respect to such labor standards the authority and functions set forth in Reorganization Plan Numbered 14 of 1950 (15 F.R. 3176; 5 U.S.C. Appendix) and section 2 of the Act of June 13, 1934 (40 U.S.C. 276c);

(I) in the case of a project for the construction or modernization of an outpatient facility, reasonable assurance that the services of a general hospital will be available to patients at such facility who are in need of hospital care; and

(J) reasonable assurance that at all times after such application is approved (i) the facility or portion thereof to be constructed, or modernized, or converted will be made available to all persons residing or employed in the area served by the facility, and (ii) there will be made available in the facility or portion thereof to be constructed, modernized, or converted a reasonable volume of services to persons unable to pay therefor and the Secretary, in determining the reasonableness of the volume of services provided, shall take into consideration the extent to which compliance is feasible from a financial viewpoint.

(2)(A) The Secretary may waive—

(i) the requirements of subparagraph (C) of paragraph (1) for compliance with modernization and equipment standards prescribed pursuant to section 1602(2), and

(ii) the requirement of subparagraph (D) of paragraph (1) respecting title to a project site,

in the case of an application for a project described in subparagraph (B).

(B) A project referred to in subparagraph (A) is a project—

(i) for the modernization of an outpatient medical facility which will provide general purpose health services, which is not part of a hospital, and which will serve a medically underserved population as defined in section 1633 or as designated by a health systems agency, and

(ii) for which the applicant seeks (I) not more than $20.000 from the allotments made under part B to the State in which it is located, or (II) a loan under part C the principal amount of which does not exceed $20,000.

(c) The Secretary shall approve an application submitted under subsection (b) (other than an application for a grant under section 1625) if—

(1) in the case of a project to be assisted from an allotment made under part B, there are sufficient funds in such allotment to pay the Federal share of the project; and

(2) the Secretary finds that—

(A) the application (i) is in conformity with the State medical facilities plan approved under section 1603, (ii) has been approved and recommended by the State Agency, (iii) is for a project which is entitled to priority over other projects within the State as determined in accordance with the approved State medical facilities plan, and (iv) contains the assurances required by subsection (b); and

(B) the plans and specifications for the project meet the requirements of the regulations prescribed pursuant to section 1602.

(d) No application (other than an application for a grant under section 1625) shall be disapproved until the Secretary has afforded the State Agency an opportunity for a hearing.

(e) Amendment of any approved application shall be subject to approval in the same manner as an original application.

(f) Each application shall be reviewed by health systems agencies in accordance with section 1513(e).

Part B—Allotments

allotments

Sec. 1610. (a) For each fiscal year, the Secretary shall, in accordance with regulations, make from sums appropriated for such fiscal year under section 1613 allotments among the States on the basis of the population, the financial need, and need for medical facilities projects described in section 1601 of the respective States. The population of the States shall be determined on the basis of the latest figures certified by the Secretary of Commerce.

(b) (1) The allotment to any State (other than Guam, American Samoa, the Virgin Islands, or the Trust Territory of the Pacific Islands) for any fiscal year shall be not less than $1,000,000; and the allotment to Guam, American Samoa, the Virgin Islands, and the Trust Territory of the Pacific Islands for any fiscal year shall be not less than $500,000 each.

(2) Notwithstanding paragraph (1), if the amount appropriated under section 1613 for any fiscal year is less than the amount required to provide allotments in accordance with paragraph (1), the amount of the allotment to any State for such fiscal year shall be an amount which bears the same ratio to the amount prescribed for such State by paragraph (1) as the amount appropriated for such fiscal year bears to the amount of appropriations needed to make allotments to all the States in accordance with paragraph (1).

(c) Any amount allotted to a State for a fiscal year under subsection (a) and remaining unobligated at the end of such year shall remain available to such State, for the purpose for which made, for the next two fiscal years (and for such years only), in addition to the amounts allotted to such State for such purposes for such next two fiscal years; except that any such amount which is unobligated at the end of the first of such next two years and which the Secretary determines will remain unobligated at the close of the second of such next two years may be reallotted by the Secretary, to be available for the purposes for which made until the close of the second of such next two years, to other States which have need therefor, on such basis as the Secretary deems equitable and consistent with the purposes of this title. Any amount so reallotted to a State shall be in addition to the amounts allotted and available to the State for the same period.

PAYMENTS FROM ALLOTMENTS

SEC. 1611. (a) If with respect to any medical facility project approved under section 1604 the State Agency certifies (upon the basis of inspection by it) to the Secretary that, in accordance with approved plans and specifications, work has been performed upon the project or purchases have been made for it and that payment from the applicable allotment of the State in which the project is located is due for the project, the Secretary shall, except as provided in subsection (b), make such payment to the State.

(b) The Secretary is authorized to not make payments to a State pursuant to subsection (a) in the following circumstances:

(1) If such State is not authorized by law to make payments for an approved medical facility project from the payment to be made by the Secretary pursuant to subsection (a), or if the State so requests, the Secretary shall make the payment from the State allotment directly to the applicant for such project.

(2) If the Secretary, after investigation or otherwise, has reason to believe that any act (or failure to act) has occurred requiring action pursuant to section 1612, payment by the Secretary may, after he has given the State Agency notice and opportunity for hearing pursuant to such section, be withheld, in whole or in part, pending corrective action or action based on such hearing.

In no event may the total of payments made under subsection (a) with respect to any project exceed an amount equal to the Federal share of such project.

(c) In case an amendment to an approved application is approved as provided in section 1604 or the estimated cost of a project is revised upward, any additional payment with respect thereto may be made from the applicable allotment of the State for the fiscal year in which such amendment or revision is approved.

(d) In any fiscal year—

(1) not more than 20 per centum of the amount of a State's allotment available for obligation in that fiscal year may be obligated for projects in the State for construction of new facilities for the provision of inpatient health care to persons residing in areas of the State which have experienced recent rapid population growth; and

(2) not less than 25 per centum of the amount of a State's allotment available for obligation in that fiscal year shall be obligated for projects for outpatient facilities which will serve medically underserved populations.

In the administration of this part, the Secretary shall seek to assure that in each fiscal year at least one half of the amount obligated for projects pursuant to paragraph (2) shall be obligated for projects which will serve rural medically underserved populations.

WITHHOLDING OF PAYMENTS AND OTHER COMPLIANCE ACTIONS

SEC. 1612. (a) Whenever the Secretary, after reasonable notice and opportunity for hearing to the State Agency concerned finds—

(1) that the State Agency is not complying substantially with the provisions required by section 1603 to be included in its State medical facilities plan,

(2) that any assurance required to be given in an application filed under section 1604 is not being or cannot be carried out, or

(3) that there is a substantial failure to carry out plans and specifications approved by the Secretary under section 1604,

the Secretary shall take the action authorized by subsection (b) unless, in the case of compliance with assurances, the Secretary requires compliance by other means authorized by law.

(b) (1) Upon a finding described in subsection (a) and after notice to the State Agency concerned, the Secretary may—

(A) withhold from all projects within the State with respect to which the finding was made further payments from the State's allotment under section 1610, or

(B) withhold from the specific projects with respect to which the finding was made further payments from the applicable State allotment under section 1610.

(2) Payments may be withheld, in whole or in part, under paragraph (1)—

(A) until the basis for the finding upon which the withholding was made no longer exists, or

(B) if corrective action to make such finding inapplicable cannot be made, until the State concerned repays or arranges for the

repayment of Federal funds paid under this part for projects which because of the finding are not entitled to such funds.

(c) The Secretary shall investigate and ascertain, on a periodic basis, with respect to each entity which is receiving financial assistance under this title or which has received financial assistance under title VI or this title, the extent of compliance by such entity with the assurances required to be made at the time such assistance was received. If the Secretary finds that such an entity has failed to comply with any such assurance, the Secretary shall take the action authorized by subsection (b) or take any other action authorized by law (including an action for specific performance brought by the Attorney General upon request of the Secretary) which will effect compliance by the entity with such assurances. An appropriate action to effectuate compliance with any such assurance may be brought by a person other than the Secretary only if a complaint has been filed by such person with the Secretary and the Secretary has dismissed such complaint or the Attorney General has not brought a civil action for compliance with such assurance within 6 months after the date on which the complaint was filed with the Secretary.

AUTHORIZATION OF APPROPRIATIONS

SEC. 1613. Except as provided in section 1625(d), there are authorized to be appropriated for allotments under section 1610 $125,000,000 for the fiscal year ending June 30, 1975, $130,000,000 for the fiscal year ending June 30, 1976, and $135,000,000 each for the fiscal years ending September 30, 1977, [and] September 30, 1978, *September 30, 1979, September 30, 1980, and September 30, 1981. The Secretary may make funds appropriated for use in Fiscal Year 1976 under this section but not expended available to carry out the purposes of section 1625(d) through September 30, 1979.*

PART C—LOANS AND LOAN GUARANTEES

AUTHORITY FOR LOANS AND LOAN GUARANTEES

SEC. 1620. (a) The Secretary, during the period beginning July 1, 1974, and ending September 30, 1978, may, in accordance with this part, make loans from the fund established under section 1622(d) to pay the Federal share of projects approved under section 1604.

(b)(1) The Secretary, during the period beginning July 1, 1974, and ending September 30, 1978, may, in accordance with this part, guarantee to—

(i) non-Federal lenders for their loans to nonprofit private entities for medical facilities projects, and

(ii) the Federal Financing Bank for its loans to nonprofit private entities for such projects,

payment of principal and interest on such loans if applications for assistance for such projects under this title have been approved under section 1604.

(2) In the case of a guarantee of any loan to a nonprofit private entity under this title, the Secretary shall pay, to the holder of such loan and for and on behalf of the project for which the loan was made

amounts sufficient to reduce by 3 per centum per annum the net effective interest rate otherwise payable on such loan. Each holder of such a loan which is guaranteed under this title shall have a contractual right to receive from the United States interest payments required by the preceding sentence.

(c) The cumulative total of the principal of the loans outstanding at any time with respect to which guarantees have been issued, or which have been directly made, may not exceed such limitations as may be specified in appropriation Acts.

(d) The Secretary, with the consent of the Secretary of Housing and Urban Development, shall obtain from the Department of Housing and Urban Development such assistance with respect to the administration of this part as will promote efficiency and economy thereof.

ALLOCATION AMONG THE STATES

SEC. 1621. (a) For each fiscal year, the total amount of principal of—

(1) loans to nonprofit private entities which may be guaranteed, or

(2) loans which may be directly made,

under this part shall be allotted by the Secretary among the States, in accordance with regulations, on the basis of the population, financial need, and need for medical facilities projects described in section 1601 of the respective States. The population of the States shall be determined on the basis of the latest figures certified by the Secretary of Commerce.

(b) Any amount allotted to a State for a fiscal year under subsection (a) and remaining unobligated at the end of such year shall remain available to such State, for the purpose for which made, for the next two fiscal years (and for such years only), in addition to the amounts allotted to such State for such purposes for such next two fiscal years; except that any such amount which is unobligated at the end of the first of such next two years and which the Secretary determines will remain unobligated at the close of the second of such next two years may be reallotted by the Secretary, to be available for the purposes for which made until the close of the second of such next two years, to other States which have need therefor, on such basis as the Secretary deems equitable and consistent with the purposes of this title. Any amount so reallotted to a State shall be in addition to the amounts allotted and available to the State for the same period.

GENERAL PROVISIONS RELATING TO LOAN GUARANTEES AND LOANS

SEC. 1622. (a)(1) The Secretary may not approve a loan guarantee for a project under this part unless he determines that (A) the terms, conditions, security (if any), and schedule and amount of repayments with respect to the loan are sufficient to protect the financial interests of the United States and are otherwise reasonable, including a determination that the rate of interest does not exceed such per centum per annum on the principal obligation outstanding as the Secretary determines to be reasonable, taking into account the range of interest rates prevailing in the private market for similar loans and the risks as-

sumed by the United States, and (B) the loan would not be available on reasonable terms and conditions without the guarantee under this part.

(2) (A) The United States shall be entitled to recover from the applicant for a loan guarantee under this part the amount of any payment made pursuant to such guarantee, unless the Secretary for good cause waives such right of recovery; and, upon making any such payment, the United States shall be subrogated to all of the rights of the recipient of the payments with respect to which the guarantee was made.

(B) To the extent permitted by subparagraph (C), any terms and conditions applicable to a loan guarantee under this part (including terms and conditions imposed under subparagraph (D) may be modified by the Secretary to the extent he determines it to be consistent with the financial interest of the United States.

(C) Any loan guarantee made by the Secretary under this part shall be incontestable (i) in the hands of an applicant on whose behalf such guarantee is made unless the applicant engaged in fraud or misrepresentation in securing such guarantee, and (ii) as to any person (or his successor in interest) who makes or contracts to make a loan to such applicant in reliance thereon unless such person (or his successor in interest) engaged in fraud or misrepresentation in making or contracting to make such loan.

(D) Guarantees of loans under this part shall be subject to such further terms and conditions as the Secretary determines to be necessary to assure that the purpose of this title will be achieved.

(b) (1) The Secretary may not approve a loan under this part unless—

(A) the Secretary is reasonably satisfied that the applicant under the project for which the loan would be made will be able to make payments of principal and interest thereon when due, and

(B) the applicant provides the Secretary with reasonable assurance that there will be available to it such additional funds as may be necessary to complete the project or undertaking with respect to which such loan is requested.

(2) Any loan made under this part shall (A) have such security, (B) have such maturity date, (C) be repayable in such installments, (D) bear interest at a rate comparable to the current rate of interest prevailing, on the date the loan is made, with respect to loans guaranteed under this part, minus 3 per centum per annum, and (E) be subject to such other terms and conditions (including provisions for recovery in case of default), as the Secretary determines to be necessary to carry out the purposes of this title while adequately protecting the financial interests of the United States.

(3) The Secretary may, for good cause but with due regard to the financial interests of the United States, waive any right of recovery which he has by reasons of the failure of a borrower to make payments of principal of and interest on a loan made under this part, except that if such loan is sold and guaranteed, any such waiver shall have no effect upon the Secretary guarantee of timely payment of principal and interest.

(c) (1) The Secretary shall from time to time, but with due regard to the financial interests of the United States, sell loans made under

this part either on the private market or to the Federal National Mortgage Assocation in accordance with section 302 of the Federal National Mortgage Association Charter Act or to the Federal Financing Bank.

(2) Any loan so sold shall be sold for an amount which is equal (or approximately equal) to the amount of the unpaid principal of such loans as of time of sale.

(3) (A) The Secretary is authorized to enter into an agreement with the purchaser of any loan sold under this part under which the Secretary agrees—

(i) to guarantee to such purchaser (and any successor in interest to such purchaser) payments of the principal and interest payable under such loan, and

(ii) to pay as an interest subsidy to such purchaser (and any successor in interest of such purchaser) amounts which, when added to the amount of interest payable on such loan, are equivalent to a reasonable rate of interest on such loan as determined by the Secretary after taking into account the range of prevailing interest rates in the private market on similar loans and the risks assumed by the United States.

(B) Any agreement under subparagraph (A)—

(i) may provide that the Secretary shall act as agent of any such purchaser, for the purpose of collecting from the entity to which such loan was made and paying over to such purchaser any payments of principal and interest payable by such entity under such loan;

(ii) may provide for the repurchase by the Secretary of any such loan on such terms and conditions as may be specified in the agreement;

(iii) shall provide that, in the event of any default by the entity to which such loan was made in payment of principal or interest due on such loan, the Secretary shall, upon notification to the purchaser (or to the successor in interest of such purchaser), have the option to close out such loan (and any obligations of the Secretary with respect thereto) by paying to the purchaser (or his successor in interest) the total amount of outstanding principal and interest due thereon at the time of such notification; and

(iv) shall provide that, in the event such loan is closed out as provided in clause (iii), or in the event of any other loss incurred by the Secretary by reason of the failure of such entity to make payments of principal or interest on such loan, the Secretary shall be subrogated to all rights of such purchaser for recovery of such loss from such entity.

(4) Amounts received by the Secretary as proceeds from the sale of loans under this subsection shall be deposited in the fund established under subsection (d).

(5) If any loan to a public entity under this part is sold and guaranteed by the Secretary under this subsection, interest paid on such loan after its sale and any interest subsidy paid, under paragraph (3) (A) (ii), by the Secretary with respect to such loan which is received by the purchaser of the loan (or the purchaser's successor in interest)

shall be included in the gross income of the purchaser or successor for the purpose of chapter 1 of the Internal Revenue Code of 1954.

(d) (1) There is established in the Treasury a loan and loan guarantee fund (hereinafter in this subsection referred to as the "fund") which shall be available to the Secretary without fiscal year limitation, in such amounts as may be specified from time to time in appropriation Acts—

(A) to enable him to make loans under this part,

(B) to enable him to discharge his responsibilities under loan guarantees issued by him under this part.

(C) for payment of interest under section 1620(b) (2) on loans guaranteed under this part,

(D) for repurchase of loans under subsection (c) (3) (B), and

(E) for payment of interest on loans which are sold and guaranteed.

There are authorized to be appropriate from time to time such amounts as may be necessary to provide the sums required for the fund. There shall also be deposited in the fund amounts received by the Secretary in connection with loans and loan guarantees under this part and other property or assets derived by him from his operations respecting such loans and loan guarantees, including any money derived from the sale of assets.

(2) If at any time the sums in the funds are insufficient to enable the Secretary—

(A) to make payments of interest under section 1620(b) (2),

(B) to otherwise comply with guarantees under this part of loans to nonprofit private entities,

(C) in the case of a loan which was made, sold, and guaranteed under this part, to make to the purchaser of such loan payments of principal and interest on such loan after default by the entity to which the loan was made, or

(D) to repurchase loans under subsection (c) (3) (B), and

(E) to make payments of interest on loans which are sold and guaranteed.

he is authorized to issue to the Secretary of the Treasury note or other obligations in such forms and denominations bearing such maturities, and subject to such terms and conditions, as may be prescribed by the Secretary with the approval of the Secretary of the Treasury. Such notes or other obligations shall bear interest at a rate determined by the Secretary of the Treasury, taking into consideration the current average market yield on outstanding marketable obligations of the United States of comparable maturities during the month preceding the issuance of the notes or other obligations. The Secretary of the Treasury shall purchase any notes and other obligations issued under this paragraph and for that purpose he may use as a public debt transaction the proceeds from the sale of any securities issued under the Second Liberty Bond Act, and the purposes for which the securities may be issued under that Act are extended to include any purchase of such notes and obligations. The Secretary of the Treasury may at any time sell any of the notes or other obligations acquired by him under this paragraph. All redemptions, purchases, and sales by the Secretary of the Treasury of such notes or other obligations shall be treated as public debt transactions of the United States. Sums bor-

rowed under this paragraph shall be deposited in the fund and redemption of such notes and obligations shall be made by the Secretary from the fund.

(e) (1) The assets, commitments, obligations, and outstanding balances of the loan guarantee and loan fund established in the Treasury by section 626 shall be transferred to the fund established by subsection (d) of this section.

(2) To provide additional capitalization for the fund established under subsection (d) there are authorized to be appropriated to the fund, such sums as may be necessary for the fiscal years ending June 30, 1975, June 30, 1976, September 30, 1977, [and] September 30, 1978. *September 30, 1979, September 30, 1980 and September 30, 1981.*

Part D—Project Grants

project grants

Sec. 1625. (a) The Secretary may make grants for construction or modernization projects designed to (1) eliminate or prevent imminent safety hazards as defined by Federal, State, or local fire, building, or life safety codes or regulations, or (2) avoid noncompliance with State or voluntary licensure or accreditation standards. A grant under this subsection may only be made to a State or political subdivision of a State, including any city, town, county, borough, hospital district authority, or public or quasi-public corporation, for a project described in the preceding sentence for any medical facility owned or operated by it.

(b) An application for a grant under subsection (a) may not be approved under section 1604 unless it contains assurances satisfactory to the Secretary that the applicant making the application would not be able to complete the project for which the application is submitted without the grant applied for.

(c) The amount of any grant under subsection (a) may not exceed 75 per centum of the cost of the project for which the grant is made unless the project is located in an area determined by the Secretary to be an urban or rural poverty area, in which case the grant may cover up to 100 per centum of such costs.

(d) Of the sums appropriated under section 1613 for a fiscal year, there shall be made available for grants under subsection (a) for such fiscal year 22 per centum of such sums. In addition to the amounts made available for such grants under the preceding sentence for [the fiscal year ending September 30, 1978,] *the fiscal years ending September 30, 1978, September 30, 1979, September 30, 1980, and September 30, 1981* there are authorized to be appropriated $67,500,000 [for such fiscal year] *$75,000,000, $100,000,000 and $125,000,000 for such fiscal years, respectively,* for such grants.

Part E—General Provisions

judiciary review

Sec. 1630. If—

(1) the Secretary refuses to approve an application for a project submitted under section 1604, the State Agency through which such application was submitted, or

(2) any State is dissatisfied with, or any entity will be adversely affected by, the Secretary's action under section 1612, such State or entity,

may appeal to the United States court of appeals for the circuit in which such State Agency, State, or entity is located, by filing a petition with such court within sixty days after such action. A copy of the petition shall be forthwith transmitted by the clerk of the court to the Secretary, or any officer designated by him for that purpose. The Secretary thereupon shall file in the court the record of the proceedings on which he based his action, as provided in section 2112 of title 28, United States Code. Upon the filing of such petition, the court shall have jurisdiction to affirm the action of the Secretary or to set it aside, in whole or in part, temporarily or permanently, but until the filing of the record, the Secretary may modify or set aside his order. The findings of the Secretary as to the facts, if supported by substantial evidence, shall be conclusive, but the court, for good cause shown, may remand the case to the Secretary to take further evidence, and the Secretary may thereupon make new or modified findings of fact and may modify his previous action, and shall file in the court the record of the further proceedings. Such new or modified findings of fact shall likewise be conclusive if supported by substantial evidence. The judgment of the court affirming or setting aside, in whole or in part, any action of the Secretary shall be final, subject to review by the Supreme Court of the United States upon certiorari or certification as provided in section 1254 of title 28, United States Code. The commencement of proceedings under this section shall not, unless so specifically ordered by the Court, operate as a stay of the Secretary's action.

RECOVERY

SEC. 1631. (a) If any facility constructed, modernized, or converted with funds provided under this title is, at any time within twenty years after the completion of such construction, modernization, or conversion with such funds—

(1) sold or transferred to any person or entity (A) which is not qualified to file an application under section 1604, or (B) which is not approved as a transferee by the State Agency of the State in which such facility is located, or its successor; or

(2) not used as a medial facility, and the Secretary has not determined that there is good cause for termination of such use,

the United States shall be entitled to recover from either the transferor or the transferee in the case of a sale or transfer or from the owner in case of termination of use an amount bearing the same ratio to the then value (as determined by the agreement of the parties or by action brought in the district court of the United States for the district in which the facility is situated) of so much of such facility as constituted an approved project or projects, as the amount of the Federal participation bore to the cost of the construction, modernization, or conversion of such project or projects. Such right of recovery shall not constitute a lien upon such facility prior to judgment.

(b) The Secretary may waive the recovery rights of the United States under subsection (a) with respect to a facility in any State—

(1) if (as determined under regulations prescribed by the Secretary) the amount which could be recovered under subsection (a) with respect to such facility is applied to the development, expansion, or support of another medical facility located in such State which has been approved by the Statewide Health Coordinating Council for such State as consistent with the State health plan established pursuant to section 1524(c); or

(2) if the Secretary determines, in accordance with regulations that there is good cause for waiving such requirement with respect to such facility.

If the amount which the United States is entitled to recover under subsection (a) exceeds 90 per centum of the total cost of the construction or modernization project for a facility, a waiver under this subsection shall only apply with respect to an amount which is not more than 90 per centum of such total cost.

STATE CONTROL OF OPERATIONS

SEC. 1632. Except as otherwise specifically provided, nothing in this title shall be construed as conferring on any Federal officer or employee the right to exercise any supervision or control over the administration, personnel, maintenance, or operation of any facility with respect to which any funds have been or may be expended under this title.

DEFINITIONS

SEC. 1633. For the purposes of this title—

(1) The term "State" includes the Commonwealth of Puerto Rico, the Northern Mariana Islands, Guam, American Samoa, the Trust Territory of the Pacific Islands, the Virgin Islands, and the District of Columbia.

(2) The term "Federal share" means the proportion of the cost of a medical facilities project which the State Agency determines the Federal Government will provide under allotment payments or a loan or loan guarantee under this title, except that—

(A) in the case of a modernization project—

(i) described in section 1604(b)(2)(B), and

(ii) the application for which received a waiver under section 1604(b)(2)(A),

the proportion of the cost of such project to be paid by the Federal Government under allotment payments or a loan may not exceed $20,000 and may not exceed 100 per centum of the first $6,000 of the cost of such project and 66⅔ per centum of the next $21,000 of such cost,

(B) in the case of a project (other than a project described in subparagraph (A)) to be assisted from an allotment made under part B, the proportion of the cost of such project to be paid by the Federal Government may not exceed 66⅔ unless the project is located in an area determined by the Secretary to be an urban or rural poverty area, in which case the proportion of the cost of such project to be paid by the Federal Government may be 100 per centum, and

27-409 O - 78 - 11

(C) in the case of a project (other than a project described in subparagraph (A)) to be assisted with a loan or loan guarantee made under part C, the principal amount of the loan directly made or guaranteed for such project, when added to any other assistance provided the project under this title, may not exceed 90 per centum of the cost of such project unless the project is located in an area determined by the Secretary to be an urban or rural poverty area, in which case the principal amount, when added to other assistance under this title, may cover up to 100 per centum of the cost of the project.

(3) The term "hospital" includes general, tuberculosis, and other types of hospitals, and related facilities, such as laboratories, outpatient departments, nurses' home facilities, extended care facilities, facilities related to programs for home health services, self-care units, and central services facilities, operated in connection with hospitals, and also includes education or training facilities for health professional personnel operated as an integral part of a hospital, but does not include any hospital furnishing primarily domiciliary care.

(4) The term "public health center" means a publicly owned facility for the provision of public health services, including related publicly owned facilities such as laboratories, clinics, and administrative offices operated in connection with such a facility.

(5) The term "nonprofit" as applied to any facility means a facility which is owned and operated by one or more nonprofit corporations or associations no part of the net earnings of which inures, or may lawfully inure, to the benefit of any private shareholder or individual.

(6) The term "outpatient medical facility" means a medical facility (located in or apart from a hospital) for the diagnosis or diagnosis and treatment of ambulatory patients (including ambulatory inpatients)—

(A) which is operated in connection with a hospital,

(B) in which patient care is under the professional supervision of persons licensed to practice medicine or surgery in the State, or in the case of dental diagnosis or treatment, under the professional supervision of persons licensed to practice dentistry in the State; or

(C) which offers to patients not requiring hospitalization the services of licensed physicians in various medical specialties and which provides to its patients a reasonably full-range of diagnostic and treatment services.

(7) The term "rehabilitation facility" means a facility which is operated for the primary purpose of assisting in the rehabilitation of disabled persons through an integrated program of—

(A) medical evaluation and services, and

(B) psychological, social, or vocational evaluation and services,

under competent professional supervision, and in the case of which the major portion of the required evaluation and services is furnished within the facility; and either the facility is operated in connection with a hospital, or all medical and related health serv-

ices are prescribed by, or are under the general direction of, persons licensed to practice medicine or surgery in the State.

(8) The term "facility for long-term care" means a facility (including a skilled nursing or intermediate care facility) providing in-patient care for convalescent or chronic disease patients who require skilled nursing or intermediate care and related medical services—

(A) which is a hospital (other than a hospital primary for care and treatment of mentally ill or tuberculosis patients) or is operated in connection with a hospital, or

(B) in which such care and medical services are prescribed by, or are performed under the general direction of, persons licensed to practice medicine or surgery in the State.

(9) The term "construction" means construction of new buildings and initial equipment of such buildings and, in any case in which it will help to provide a service not previously provided in the community, equipment of any buildings; including architects' fees, but excluding the cost of off-site improvements and, except with respect to public health centers, the cost of the acquisition of land.

(10) The term "cost" as applied to construction modernization, or conversion means the amount found by the Secretary to be necessary for construction, modernization, or conversion, respectively, under a project, except that, in a case of a modernization project or a project assisted under part D, such term does not include any amount found by the Secretary to be attributable to expansion of the bed capacity of any facility.

(11) The term "modernization" includes the alteration, expansion, major repair (to the extent permitted by regulation), remodeling, replacement, and renovation of existing buildings (including initial equipment thereof), and the replacement of obsolete equipment of existing buildings.

(12) The term "title," when used with reference to a site for a project, means a fee simple, or such other estate or interest (including a leasehold on which the rental does not exceed 4 per centum of the value of the land) as the Secretary finds sufficient to assure for a period of not less than twenty-five years' undistrubed use and possession for the purposes of construction, modernization, or conversion and operation of the project for a period of not less than (A) twenty years in the case of a project assisted under an allotment or grant under this title, or (B) the term of repayment of a loan made or guaranteed under this title in the case of a project assisted by a loan or loan guarantee.

(13) The term "medical facility" means a hospital, public health center, outpatient medical facility, rehabilitation facility, facility for long-term care, or other facility (as may be designated by the Secretary) for the provision of health care to ambulatory patients.

(14) The term "State Agency" means the State health planning and development agency of a State designated under title XV.

(15) The term "urban or rural poverty area" means an urban or rural geographical area (as defined by the Secretary) in which

a percentage (as defined by the Secretary in accordance with the next sentence) of the residents of the area have incomes below the poverty level (as defined by the Secretary of Commerce). The percentage referred to in the preceding sentence shall be defined so that the percentage of the population of the United States residing in urban and rural poverty areas is—

(A) not more than the percentage of the total population of the United States with incomes below the poverty level (as so defined) plus five per centum, and

(B) not less than such percentage minus five per centum.

(16) The term "medically undeserved population" means the population of an urban or rural area designated by the Secretary as an area with a shortage of health facilities or a population group designated by the Secretary as having a shortage of such facilities.

FINANCIAL STATEMENTS; RECORDS AND AUDIT

SEC. 1634. (a) In the case of any facility for which an allotment payment, grant, loan, or loan guarantee has been made under this title, the applicant for such payment, grant, loan, or loan guarantee (or, if appropriate, such other person as the Secretary may prescribe) shall file at least annually with the State Agency for the State in which the facility is located a statement which shall be in such form, and contain such information, as the Secretary may require to accurately show—

(1) the financial operations of the facility, and

(2) the costs to the facility of providing health services in the facility and the charges made by the facility for providing such services,

during the period with respect to which the statement is filed.

(b)(1) Each entity receiving Federal assistance under this title shall keep such records as the Secretary shall prescribe, including records which fully disclose the amount and disposition by such entity of the proceeds of such assistance, the total cost of the project in connection with which such assistance is given or used, the amount of that portion of the cost of the project supplied by other sources, and such other records as will facilitate the effective audit.

(2) The Secretary and the Comptroller General of the United States, or any of their duly authorized representatives, shall have access for the purpose of audit and examination to any books, documents, papers, and records of such entities which in the opinion of the Secretary or the Comptroller General may be related or pertinent to the assistance referred to in paragraph (1)).

(c) Each such entity shall file at least annually with the Secretary a statement which shall be in such form, and contain such information, as the Secretary may require to accurately show—

(1) the financial operations of the facility constructed or modernized with such assistance, and

(2) the costs to such facility of providing health services in such facility, and the charges made for such services, during the period with respect to which the statement is filed.

TECHNICAL ASSISTANCE

SEC. 1635. The Secretary shall provide (either through the Department of Health, Education, and Welfare or by contract) all necessary technical and other nonfinancial assistance to any public or other nonprofit entity which is eligible to apply for assistance under this title to assist such entity in developing applications to be submitted to the Secretary under section 1604. The Secretary shall make every effort to inform eligible applicants of the availability of assistance under this title.

PART F—AREA HEALTH SERVICES DEVELOPMENT FUNDS

DEVELOPMENT GRANTS FOR AREA HEALTH SERVICES DEVELOPMENT FUNDS

SEC. 1640. (a) The Secretary shall make in each fiscal year a grant to each health system agency—

(1) with which there is in effect a designation agreement under section 1515(c),

(2) which has in effect an HSP and AIP reviewed by the Statewide Health Coordinating Council, and

(3) which, as determined under the review made under section 1535(c), is organized and operated in the manner prescribed by section 1512(b) and is performing its functions under section 1513 in a manner satisfactory to the Secretary,

to enable the agency to establish and maintain an Area Health Services Development Fund from which it may make grants and enter into contracts in accordance with section 1513(c)(3).

(b)(1) Except as provided in paragraph (2), the amount of any grant under subsection (a) shall be determined by the Secretary after taking into consideration the population of the health service area for which the health systems agency is designated, the average family income of the area, and the supply of health services in the area.

(2) The amount of any grant under subsection (a) to a health systems agency for any fiscal year may not exceed the product of $1 and the population of the health service area for which such agency is designated.

(c) No grant may be made under subsection (a) unless an application therefor has been submitted to, and approved by, the Secretary. Such an application shall be submitted in such form and manner and contain such information as the Secretary may require.

(d) For the purpose of making payments pursuant to grants under subsection (a), there are authorized to be appropriated $25,000,000 for the fiscal year ending June 30, 1975, $75,000,000 for the fiscal year ending June 30, 1976, and $120,000,00 each for the fiscal years ending September 30, 1977, [and] September 30, 1978, *$120,000,000 for the fiscal year ending September 30, 1979, $150,000,000 for the fiscal year ending September 30, 1980, and $180,000,000 for the fiscal year ending September 30, 1981.*

Part G—Program To Assist and Encourage the Voluntary Discontinuance of Unneeded Hospital Services

ESTABLISHMENT OF PROGRAM

Sec. 1641. The Secretary shall, by April 1, 1979, establish a program under which financial assistance and encouragement shall be provided, in accordance with this part, for the consolidation of duplicative hospital services and the discontinuance of unneeded hospital services.

ASSISTANCE UNDER THE PROGRAM

Sec. 1642. (a)(1) Under the program established under section 1641, any hospital which was in operation on the date of enactment of this part and—

(A) which intends to discontinue providing inpatient health services may apply for a debt payment and an incentive payment under section 1643 for such discontinuance,

(B) which intends to discontinue an identifiable unit of the hospital which provides inpatient health services may apply for an incentive payment under section 1643 for such discontinuance, or

(C) which intends to convert an identifiable part of the hospital into providing ambulatory care services, long-term care services, or any other service designated by the Secretary may apply for a conversion payment under section 1643 if the State health planning and development agency which would have jurisdiction over such service has determined, after taking into consideration the recommendations of the health systems agency which would have jurisdiction over such service, that such service is needed.

(2) The incentive payment authorized by paragraph (a)(1) may be used for—

(A) the planning, development (including the cost of construction and the acquisition of equipment), and delivery of ambulatory care services, home health care services, long-term care services, or other services (designated by the Secretary) for the community served by the applicant for such payment, which services the State health planning and development agency, after consideration of the recommendations of the health systems agency with jurisdiction over such community, has determined are needed;

(B) if the applicant has merged with another hospital, preparation of that hospital to serve patients of the closed hospital;

(C) reasonable (as determined under guidelines prescribed by the Secretary) termination pay for personnel of the applicant who will lose employment because of the discontinuance of inpatient services to be made by the applicant, retraining of such personnel, and assisting such personnel in securing employment; or

(D) any combination of the activities described in subparagraphs (A), (B), and (C).

(b) An application of a hospital for a payment under section 1643 shall include—

(1) a description of the service (or services) to be discontinued or the part of the hospital to be converted;

(2) an evaluation of the impact of such discontinuance or conversion on the provision of health care in the health service area in which such hospital is located;

(3) if the services of a unit of a hospital or of all services of a hospital are to be discontinued or converted, an estimate of the change in the applicant's revenues which will result from such discontinuance or conversion;

(4) with respect to the incentive payment for the discontinuance of all the services of hospital—

(A) a description of the activities for which the applicant intends to expend such payment,

(B) a description of the means with which (including a description of any Federal financial assistance the applicant intends to apply for), and the manner in which, the applicant will carry out such activities,

(C) the amount the applicant intends to expend for such activities, and

(D) if the applicant will not be responsible for making expenditures for such activities, identification of the person (or persons) who will be responsible for making such expenditures;

(5) with respect to the incentive payment for the discontinuance of an identifiable unit of a hospital, a description of the use the applicant will make of such payment;

(6) an evaluation of the impact of such discontinuance or conversion on the employees of such hospital; and

(7) such other information as the Secretary may by regulation require.

A hospital which has an application under this subsection approved by the Secretary is entitled to receive the payments applied for.

(c) The health systems agency for the health service area in which an applicant under this section is located shall determine the need for the service (or services) proposed to be discontinued by such applicant or for the part of the hospital to be converted, as the case may be, and shall make a recommendation to the State health planning and development agency for the State in which the applicant is located respecting approval by the Secretary of such applicant's application. A determination of a health systems agency under this subsection shall be based upon criteria developed pursuant to section 1532(c).

(d) A State health planning and development agency which has received a recommendation from a health systems agency under subsection (c) shall, after consideration of such recommendation, make a recommedation, to the Secretary respecting the approval by the Secretary of the application with respect to which the health systems agency's recommendation was made. A State health planning and development agency's recommendation under this subsection with respect to the approval of an application (1) shall be based upon (A) the need for the service (or services) proposed to be discontinued by the applicant or for the part of the hospital to be converted, as the case may be, and (B) such other criteria as the Secretary may by regulation prescribe,

and (2) shall be accompanied by the health systems agency's recommendation made with respect to the approval of such application.

(e) In considering applications submitted under this section, the Secretary shall consider the recommendations of the State health planning and development agency and the health systems agency. The Secretary may not approve an application which a State agency recommends not be approved.

(f) In determining the need for the service (or services) proposed to be discontinued by an applicant for payment under section 1643, a health systems agency and a State agency shall give special consideration to the unmet needs and existing access patterns of urban or rural poverty populations.

(g) For purposes of this title, the term "hospital" means, with respect to any fiscal year, an institution (including a distinct part of an institution participating in the program established under XVIII of the Social Security Act) which satisfies paragraphs (1) and (7) of section 1861(e) of such Act, but such term does not include a Federal hospital.

AMOUNT OF PAYMENTS

SEC. 1643. (a) The amount of a debt payment which shall be made to a hospital, with an approved application under section 1642 for the discontinuance of all of its inpatient services is the sum of—

(1) (A) the lesser of—

(i) the total outstanding financial obligation of the applicant attributable (as determined under regulations promulgated by the Secretary) to the acquisition of equipment and facilities of the hospital, or

(ii) the amount of unexpensed depreciation attributable (as determined under regulations promulgated by the Secretary) to the equipment and facilities of the hospital, less—

(B) the fair market value (as defined by the Secretary) of the equipment and facilities of the hospital; and

(2) any other expenses (as defined by regulation by the Secretary) which result from the financial obligation of the applicant being satisfied before due.

(b) The amount of an incentive payment which shall be made to a hospital, with an approved application under section 1642 for the discontinuance of all of its services or the services of an identifiable unit of the hospital is—

(1) in the case of the discontinuance of all of the inpatient services of a hospital, an amount not to exceed the amount reported by the hospital under section 1642, and

(2) in the case of the discontinuance of the services of an identifiable unit of the hospital, an amount not to exceed 30 per centum of the charges reported by the hospital for such unit in the previous hospital accounting fiscal year pursuant to generally acceptable accounting principles prescribed by regulations of the Secretary.

(c) The amount of a conversion payment which shall be made to a hospital, with an approved application under section 1642 is 50 per centum of the reasonable (as determined by criteria established in

regulations of the Secretary) cost of the conversion approved in such application.

(d) The debt payment, incentive payment, and conversion payment to which a hospital is entitled shall be paid in a single payment.

(e) If an incentive payment is to be made for the discontinuance of all the services of a hospital or an identifiable unit of a hospital, the health systems agency designated for the health service area in which such hospital is located shall receive a payment equal to 10 per centum of such incentive payment. Such health systems agency may use a payment under this paragraph only to make grants and contracts in accordance with section 1513(c)(3) for projects and programs within the community served by such hospital or if such community does not need any such project or program, within another community.

(f) The Secretary shall not make a payment pursuant to this section until the Secretary of Labor has certified that fair and equitable arrangements have been made to protect the interests of employees affected by the discontinuance of services against a worsening of their positions with respect to their employment including, but not limited to, arrangements to preserve the rights of employees under collective-bargaining agreements; continuation of collective-bargaining rights consistent with the provisions of the National Labor Relations Act; reassignment of affected employees to other jobs; retraining programs; protecting pension, health benefits, and other fringe benefits of affected employees; and arranging adequate severance pay, if necesary. Procedures for certification by the Secretary of Labor shall conform to standards established by the Secretary of Labor by regulation.

(g) To make the payments required by this part, there are authorized to be appropriated $150,000,000 for the fiscal year ending September 30, 1979, $200,000,000 for the fiscal year ending September 30, 1980, and $250,000,000 for the fiscal year ending September 30, 1981.

STUDY

SEC. 1644. The Secretary shall make a study of the first twenty-five applications approved under section 1642 to determine their effect on the elimination of unneeded hospital services. The Secretary shall report the results of such study to Congress together with his recommendations for any revision in the program which he determines to be appropriate, including any revision in the authorization of appropriations for such program.

GRANTS FOR COMPREHENSIVE HEALTH PLANNING AND PUBLIC HEALTH SERVICES

Grants to States for Comprehensive State Health Planning

SEC. 314.[1] [(a)(1) AUTHORIZATION.—In order to assist the States in comprehensive and continuing planning for their current and future health needs, the Secretary is authorized during the period beginning July 1, 1966, and ending June 30, 1973, to make grants to States which have submitted, and had approved by the Secretary, State plans

[1] This subsection has been superseded by title XV.

for comprehensive State health planning. For the purposes of carrying out this subsection, there are hereby authorized to be appropriated $2,500,000 for the fiscal year ending June 30, 1967, $7,000,000 for the fiscal year ending June 30, 1968, $10,000,000 for the fiscal year ending June 30, 1969, $15,000,000 for the fiscal year ending June 30, 1970, $15,000,000 for the fiscal year ending June 30, 1971, $17,000,000 for the fiscal year ending June 30, 1972, $20,000,000 for the fiscal year ending June 30, 1973, and $10,000,000 for the fiscal year ending June 30, 1974.

[(2) STATE PLANS FOR COMPREHENSIVE STATE HEALTH PLANNING.—In order to be approved for purposes of this subsection, a State plan for comprehensive State health planning must—

[(A) designate, or provide for the establishment of, a single State agency, which may be an interdepartmental agency, as the sole agency for administering or supervising the administration of the State's health planning functions under the plan;

[(B) provide for the establishment of a State health planning council, which shall include representatives of Federal, State, and local agencies (including as an ex officio member, if there is located in such State one or more hospitals or other health care facilities of the Veterans' Administration, the individual whom the Administrator of Veterans' Affairs shall have designated to serve on such council as the representative of the hospitals or other health care facilities of such Administration which are located in such State) and nongovernmental organizations and groups concerned with health, (including representation of the regional medical program or programs included in whole or in part within the State), and of consumers of health services, to advise such State agency in carrying out its functions under the plan, and a majority of the membership of such council shall consist of representatives of consumers of health services;

[(C) set forth policies and procedures for the expenditure of funds under the plan, which, in the judgment of the Secretary, are designed to provide for comprehensive State planning for health services (both public and private and including home health care), including the facilities and persons required for the provision of such services, to meet the health needs of the people of the State and including environmental considerations as they relate to public health;

[(D) provide for encouraging cooperative efforts among governmental or nongovernmental agencies, organizations and groups concerned with health services, facilities, or manpower, and for cooperative efforts between such agencies, organizations, and groups and similar agencies, organizations, and groups in the fields of education, welfare, and rehabilitation;

[(E) contain or be supported by assurances satisfactory to the Secretary that the funds paid under this subsection will be used to supplement and, to the extent practicable, to increase the level of funds that would otherwise be made available by the State for the purpose of comprehensive health planning and not to supplant such non-Federal funds;

[(F)[1] provide such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods) as are found by the Secretary to be necessary for the proper and efficient operation of the plan;

[(G) provide that the State agency will make such reports, in such form and containing such information, as the Secretary may from time to time reasonably require, and will keep such records and afford such access thereto as the Secretary finds necessary to assure the correctness and verification of such reports;

[(H) provide that the State agency will from time to time, but not less often than annually, review its State plan approved under this subsection and submit to the Secretary appropriate modifications thereof;

[(I) effective July 1, 1968, (i) provide for assisting each health care facility in the State to develop a program for capital expenditures for replacement, modernization, and expansion which is consistent with an overall State plan developed in accordance with criteria established by the Secretary after consultation with the State which will meet the needs of the State for health care facilities, equipment, and services without duplication and otherwise in the most efficient and economical manner, and (ii) provide that the State agency furnishing such assistance will periodically review the program (developed pursuant to clause (i)) of each health care facility in the State and recommended appropriate modification thereof;

[(J) provide for such fiscal control and fund accounting procedures as may be necessary to assure proper disbursement of and accounting for funds paid to the State under this subsection; and

[(K) contain such additional information and assurances as the Secretary may find necessary to carry out the purposes of this subsection.

[(3) (A) STATE ALLOTMENTS.—From the sums appropriated for such purpose for each fiscal year, the several States shall be entitled to allotments determined, in accordance with regulations, on the basis of the population and the per capita income of the respective States; except that no such allotment to any State for any fiscal year shall be less than 1 per centum of the sum appropriated for such fiscal year pursuant to paragraph (1). Any such allotment to a State for a fiscal year shall remain available for obligation by the State, in accordance with the provisions of this subsection and the State's plan approved thereunder, until the close of the succeeding fiscal year.

[(B) The amount of any allotment to a State under subparagraph (A) for any fiscal year which the Secretary determines will not be required by the State, during the period for which it is available, for the purposes for which allotted shall be available for reallotment by

[1] Sec. 208(a)(3) of P.L. 91-648 (42 U.S.C. 4728) transferred to the U.S. Civil Service Commission all functions, powers, and duties of the Secretary under any law applicable to a grant program which requires the establishment and maintenance of personnel standards on a merit basis with respect to the program.

the Secretary from time to time, on such date or dates as he may fix, to other States with respect to which such a determination has not been made, in proportion to the original allotments to such States under subparagraph (A) for such fiscal year, but with such proportionate amount for any of such other States being reduced to the extent it exceeds the sum the Secretary estimates such State needs and will be able to use during such period; and the total of such reductions shall be similarly reallotted among the State whose proportionate amounts were not so reduced. Any amount so reallotted to a State from funds appropriated pursuant to this subsection for a fiscal year shall be deemed part of its allotment under subparagraph (A) for such fiscal year.

[(4) PAYMENTS TO STATES.—From each State's allotment for a fiscal year under this subsection, the State shall from time to time be paid the Federal share of the expenditures incurred during that year or the succeeding year pursuant to its State plan approved under this subsection. Such payments shall be made on the basis of estimates by the Secretary of the sums the State will need in order to perform the planning under its approved State plan under this subsection, but with such adjustments as may be necessary to take account of previously made underpayments or overpayments. The "Federal share" for any State for purposes of this subsection shall be all, or such part as the Secretary may determine, of the cost of such planning, except that in the case of the allotments for the fiscal year ending June 30, 1970, it shall not exceed 75 per centum, of such cost.

Project Grants for Areawide Health Planning

[(b) (1) (A) The Secretary is authorized, during the period beginning July 1, 1966, and ending June 30, 1974, to make, with the approval of the State agency administering or supervising the administration of the State plan approved under subsection (a), project grants to any other public or nonprofit private agency or organization (but with appropriate representation of the interests of local government where the recipient of the grant is not a local government or combination thereof or an agency of such government or combination) to cover not to exceed 75 per centum of the costs of projects for developing (and from time to time revising) comprehensive regional, metropolitan area, or other local area plans for coordination of existing and planned health services, including the facilities and persons required for provision of such services; and including the provision of such services through home health care; except that in the case of project grants made in any State prior to July 1, 1968, approval of such State agency shall be required only if such State has such a State plan in effect at the time of such grants. No grant may be made under this subsection after June 30, 1970, to any agency or organization to develop or revise health plans for an area unless the Secretary determines that such agency or organization provides means for appropriate representation of the interests of the hospitals, other health care facilities, and practicing physicians serving such area, and the general public. For the purposes of carrying out this subsection, there are hereby authorized to be appropriated $5,000,000 for the fiscal year ending

June 30, 1967, $7,500,000 for the fiscal year ending June 30, 1968, $10,000,000 for the fiscal year ending June 30, 1969, $15,000,000 for the fiscal year ending June 30, 1970, $20,000,000 for the fiscal year ending June 30, 1971, $30,000,000 for the fiscal year ending June 3, 1972, $40,000,000 for the fiscal year ending June 30, 1973, and $25,100,000 for the fiscal year ending June 30, 1974.

[(B) Project grants may be made by the Secretary under subparagraph (A) to the State agency administering or supervising the administration of the State plan approved under subsection (a) with respect to a particular region or area, but only if (i) no application for such a grant with respect to such region or area has been filed by any other agency or organization qualified to receive such a grant, and (ii) such State agency certifies and the Secretary finds, that ample opportunity has been afforded to qualified agencies and organizations to file application for such a grant with respect to such region or area and that it is improbable that, in the foreseeable future, any agency or organization which is qualified for such a grant will file application therefor.

[(2) (A) In order to be approved under this subsection, an application for a grant under this subsection must contain or be supported by reasonable assurances that there has been or will be established, in or for the area with respect to which such grant is sought, an areawide health planning council. The membership of such council shall include representatives of public, voluntary, and non-profit private agencies, institutions, and organizations concerned with health (including representatives of the interests of local government of the regional medical program for such area, and of consumers of health services). A majority of the members of such council shall consist of representatives of consumers of health services.

[(B) In addition, an application for a grant under this subsection must contain or be supported by reasonable assurances that the areawide health planning agency has made provision for assisting health care facilities in its area to develop a program for capital expenditures for replacement, modernization, and expansion which is consistent with an overall State plan which will meet the needs of the State and the area for health care facilities, equipment, and services without duplication and otherwise in the most efficient and economical manner.

Project Grants for Training, Studies, and Demonstrations

[(c) The Secretary is also authorized, during the period beginning July 1, 1966, and ending June 30, 1974, to make grants to any public or nonprofit private agency, institution, or other organization to cover all or any part of the cost of projects for training, studies, or demonstrations looking toward the development of improved or more effective comprehensive health planning throughout the Nation. For the purposes of carrying out this subsection, there are hereby authorized to be appropriated $1,500,000 for the fiscal year ending June 30, 1967, $2,500,000 for the fiscal year ending June 30, 1968, $5,000,000 for the fiscal year ending June 30, 1969, $7,500,000 for the fiscal year ending

June 30, 1970, $8,000,000 for the fiscal year ending June 30, 1971, $10,000,000 for the fiscal year ending June 30, 1972, $12,000,000 for the fiscal year ending June 30, 1973, and $4,700,000 for the fiscal year ending June 30, 1974.]

Comprehensive Public Health Services

(d)(1) From allotments made pursuant to paragraph (4), the Secretary shall make grants to State health and mental health authorities to assist in meeting the costs of providing comprehensive public health services.

(2) No grant may be made under paragraph (1) to the State health or mental health authority of any State unless an application therefor has been submitted to and approved by the Secretary. Such an application shall be submitted in such form and manner and shall contain such information as the Secretary may require, and shall contain or be supported by assurances satisfactory to the Secretary that—

(A) the comprehensive public health services provided within the State will be provided in accordance with the State plan prepared in accordance with section 1524(c)(2) or the State plan approved under section 314(a), whichever is applicable;

(B) funds received under grants under paragraph (1) will (i) be used to supplement and, to the extent practical, to increase the level of non-Federal funds that would otherwise be made available for the purposes for which the grant funds are provided, and (ii) not be used to supplant such non-Federal funds;

(C) the State health authority, and, with respect to mental health activities, the State mental health authority will—

(i) provide for such fiscal control and fund accounting procedures as may be necessary to assure the proper disbursement of and accounting for funds received under grants under paragraph (1);

(ii) from time to time, but not less often than annually, report to the Secretary (through a uniform national reporting system and by such categories as the Secretary may prescribe) a description of the comprehensive public health services provided in the State in the fiscal year for which the grant applied for is made and the amount of funds obligated in such fiscal year for the provision of each such category of services; and

(iii) make such reports (in such form and containing such information as the Secretary may prescribe) as the Secretary may reasonably require, and keep such records and afford such access thereto as the Secretary may find necessary to assure the correctness of, and to verify, such reports;

(D) the State mental health authority will—

(i) establish and carry out a plan which—

(I) is designed to eliminate inappropriate placement in institutions of persons with mental health problems, to insure the availability of appropriate noninstitutional services for such persons, and to improve the quality of care for those with mental health problems for whom institutional care is appropriate; and

(II) shall include fair and equitable arrangements (as determined by the Secretary after consultation with the Secretary of Labor) to protect the interests of employees affected by actions described in subclause (I) including arrangements designed to preserve employee rights and benefits and to provide training and retraining of such employees where necessary and arrangements under which maximum efforts will be made to guarantee the employment of such employees;

(ii) prescribe and provide for the enforcement of minimum standards for the maintenance and operation of mental health programs and facilities (including community mental health centers) with the State; and

(iii) provide for assistance to courts and other public agencies and to appropriate private agencies to facilitate (I) screening by community mental health centers (or, if there are no such centers, other appropriate entities) of residents of the State who are being considered for inpatient care in a mental health facility to determine if such care is necessary, and (II) provision of followup care by community mental health centers (or if there are no such centers, by other appropriate entities) for residents of the State who have been discharged from mental health facilities.

(3) The Secretary shall review annually the activities undertaken by each State with an approved application to determine if the State complied with the assurances provided with the application. The Secretary may not approve an application submitted under paragraph (2) if the Secretary determines—

(A) that the State for which the application was submitted did not comply with assurances provided with a prior application under paragraph (2), and

(B) that he cannot be assured that the State will comply with the assurances provided with the application under consideration.

(4) For the purpose of determining the total amount of grants that may be made to the State health and mental authorities of each State, the Secretary shall, in each fiscal year and in accordance with regulations, allot the sums appropriated for such year under paragraph (7) among the States on the basis of the population and the financial need of the respective States. The populations of the States shall be determined on the basis of the latest figures for the population of the States available from the Department of Commerce.

(5) The Secretary shall determine the amount of any grant under paragraph (1): but the amount of grants made in any fiscal year to the public and mental health authorities of any State may not exceed the amount of the State's allotment available for obligation in such fiscal year. Payments under such grants may be made in advance or by way of reimbursement, and at such intervals and on such conditions, as the Secretary finds necessary.

(6) In any fiscal year—

(A) not less than 15 per centum of a State's allotment under paragraph (4) shall be made available only for grants under

paragraph (1) to the State's mental health authority for the provision of mental health services; and

(B) not less than—

(i) 70 per centum of the amount of a State's allotment which is made available for grants to the mental health authority, and

(ii) 70 per centum of the remainder of the State's allotment,

shall be available only for the provision services in communities of the State.

(7)(A) For payments under grants under paragraph (1) there are authorized to be appropriated $100,000,000 for fiscal year 1976, $110,000,000 for the fiscal year ending September 30, 1977, and $106,750,000 for the fiscal year ending September 30, 1978.

(B) For payments under grants under paragraph (1) for establishing and maintaining programs, described in applications under paragraph (2), for the screening, detection, diagnosis prevention, and referral for treatment of hypertension there are authorized to be appropriated $15,000,000 for fiscal year 1976, $15,000,000 for the fiscal year ending September 30, 1977, and $12,680,000 for the fiscal year ending September 30, 1978.

(e) [Repealed.]

Interchange of Personnel With States

(f)[1] (1) For the purpose of this subsection, the term "State" means a State or a political subdivision of a State, or any agency of either of the foregoing engaged in any activities related to health or designated or established pursuant to subparagraph (A) of paragraph (2) of subsection (a); the term "Secretary" means (except when used in paragraph (3)(D)) the Secretary of Health, Education, and Welfare; and the term "Department" means the Department of Health, Education, and Welfare.

(2) The Secretary is authorized, through agreements or otherwise, to arrange for assignment of officers and employees of States to the Department and assignment to States of officers and employees in the Department engaged in work related to health, for work which the Secretary determines will aid the department in more effective discharge of its responsibilities in the field of health as authorized by law, including cooperation with States and the provision of technical or other assistance. The period of assignment of any officer or employee under an arrangement shall not exceed two years.

(3)(A) Officers and employees in the Department assigned to any State pursuant to this subsection shall be considered, during such assignment, to be (i) on detail to a regular work assignment in the Department, or (ii) on leave without pay from their positions in the Department.

(B) Persons considered to be so detailed shall remain as officers or employees, as the case may be, in the Department for all purposes, except that the supervision of their duties during the period of detail

[1] Sec. 403 of P.L. 91–648 (Intergovernmental Personnel Act of 1970) repealed sec. 314(f) except with respect to the assignment of commissioned officers of the Public Health Service.

may be governed by agreement between the Department and the State involved.

(C) In the case of persons so assigned and on leave without pay—

(i) if the rate of compensation (including allowances) for their employment by the State is less than the rate of compensation (including allowances) they would be receiving had they continued in their regular assignment in the Department, they may receive supplemental salary payments from the Department in the amount considered by the Secretary to be justified, but not at a rate in excess of the difference between the State rate and the Department rate; and

(ii) they may be granted annual leave and sick leave to the extent authorized by law, but only in circumstances considered by the Secretary to justify approval of such leave.

Such officers and employees on leave without pay shall, notwithstanding any other provision of law, be entitled—

(iii) to continuation of their insurance under the Federal Employees' Group Life Insurance Act of 1954,[1] and coverage under the Federal Employees Health Benefits Act of 1959,[2] so long as the Department continues to collect the employee's contribution from the officer or employee involved and to transmit for timely deposit into the funds created under such Acts the amount of the employee's contributions and the Government's contribution from appropriations of the Department; and

(iv) (I) in the case of commissioned officers of the Service to have their service during their assignment treated as provided in section 214(d) for such officers on leave without pay, or (II) in the case of other officers and employees in the Department, to credit the period of their assignment under the arrangement under this subsection toward periodic or longevity step increases and for retention and leave accrual purposes, and, upon payment into the civil service retirement and disability fund of the percentage of their State salary, and of their supplemental salary payments, if any, which would have been deducted from a like Federal salary for the period of such assignment and payment by the Secretary into such fund of the amount which would have been payable by him during the period of such assignment with respect to a like Federal salary, to treat (notwithstanding the provisions of the Independent Offices Appropriations Act, 1959, under the head "Civil Service Retirement and Disability Fund") their service during such period as service within the meaning of the Civil Service Retirement Act;

except that no officer or employee or his beneficiary may receive any benefits under the Civil Service Retirement Act,[1] the Federal Employees Health Benefits Act of 1959, or the Federal Employees' Group Life Insurance Act of 1954, based on service during an assignment hereunder for which the officer or employee or (if he dies without making such election) his beneficiary elects to receive benefits, under any State retirement or insurance law or program, which the Civil

[1] Codified to chapter 87 of title 5, United States Code.
[2] Codified to chapter 89 of title 5, United States Code.

Service Commission determines to be similar. The Department shall deposit currently in the funds created under the Federal Employees' Group Life Insurance Act of 1954, the Federal Employees Health Benefits Act of 1959, and the civil service retirement and disability fund, respectively, the amount of the Government's contribution under these Acts on account of service with respect to which employee contributions are collected as provided in subparagraph (iii) and the amount of the Government's contribution under the Civil Service Retirement Act on account of service with respect to which payments (of the amount which would have been deducted under that Act) referred to in subparagraph (iv) are made to such civil service retirement and disability fund.

(D) Any such officer or employee on leave without pay (other than a commissioned officer of the Service) who suffers disability or death as a result of personal injury sustained while in the performance of his duty during an assignment hereunder, shall be treated, for the purposes of the Federal Employees' Compensation Act,[2] as though he were an employee, as defined in such Act, who had sustained such injury in the performance of duty. When such person (or his dependents, in case of death) entiled by reason of injury or death to benefits under that Act is also entitled to benefits from a State for the same injury or death, he (or his dependents in case of death) shall elect which benefits he will receive. Such election shall be made within one year after the injury or death, or such further time as the Secretary of Labor may for good cause allow, and when made shall be irrevocable unless otherwise provided by law.

(4) Assignment of any officer or employee in the Department to a State under this subsection may be made with or without reimbursement by the State for the compensation (or supplementary compensation), travel and transportation expenses (to or from the place of assignment), and allowances, or any part thereof, of such officer or employee during the period of assignment, and any such reimbursement shall be credited to the appropriation utilized for paying such compensation, travel or transportation expenses, or allowances.

(5) Appropriations to the Department shall be available, in accordance with the standardized Government travel regulations or, with respect to commissioned officers of the Service, the joint travel regulations, for the expenses of travel of officers and employees assigned to States under an arrangement under this subsection on either a detail or leave-without-pay basis, and, in accordance with applicable law, orders, and regulations, for expenses of transportation of their immediate families and expenses of transportation of their household goods and personal effects in connection with the travel of such officers and employees to the location of their posts of assignment and their return to their official stations.

(6) * * *

(7) * * *

(8) The appropriations to the Department shall be available, in accordance with the standardized Government travel regulations, during the period of assignment and in the case of travel to and from their

[2] Codified to chapter 81 of title 5, United States Code.

places of assignment or appointment, for the payment of expenses of travel of persons assigned to, or given appointments by, the Department under an arrangement under this subsection.

(9) All arrangements under this subsection for assignment of officers or employees in the Department to States or for assignment of officers or employees of States to the Department shall be made in accordance with regulations of the Secretary.

General

(g)(1) All regulations and amendments thereto with respect to grants to States under subsection (a) shall be made after consultation with a conference of the State health planning agencies designated or established pursuant to subparagraph (A) of paragraph (2) of subsection (a). All regulations and amendments thereto with respect to grants to States under subsection (d) shall be made after consultation with a conference of State health authorities and, in the case of regulations and amendments which relate to or in any way affect grants for services or other activities in the field of mental health, the State mental health authorities. Insofar as practicable, the Secretary shall obtain the agreement, prior to the issuance of such regulations or amendments, of the State authorities or agencies with whom such consultation is required.

(2) The Secretary, at the request of any recipient of a grant under this section, may reduce the payments to such recipient by the fair market value of any equipment or supplies furnished to such recipient and by the amount of the pay, allowances, traveling expenses, and any other costs in connection with the detail of an officer or employee to the recipient when such furnishing or such detail, as the case may be, is for the convenience of and at the request of such recipient and for the purpose of carrying out the State plan or the project with respect to which the grant under this section is made. The amount by which such payments are so reduced shall be available for payment of such costs (including the costs of such equipment and supplies) by the Secretary, but shall, for purposes of determining the Federal share under subsection (a) or (d), be deemed to have been paid to the State.

(3) Whenever the Secretary, after reasonable notice and opportunity for hearing to the health authority or, where appropriate, the mental health authority of a State or a State health planning agency designated or established pursuant to subparagraph (A) of paragraph (2) of subsection (a), finds that, with respect to money paid to the State out of appropriations under subsection (a) or (d), there is a failure to comply substantially with either—

(A) the applicable provisions of this section;

(B) the State plan submitted under such subsection; or

(C) applicable regulations under this section;

the Secretary shall notify such State health authority, mental health authority, or health planning agency, as the case may be, that further payments will not be made to the State from appropriations under such subsection (or in his discretion that further payments will not be made to the State from such appropriations

for activities in which there is such failure), until he is satisfied that there will no longer be such failure. Until he is so satisfied, the Secretary shall make no payment to such State from appropriations under such subsection, or shall limit payment to activities in which there is no such failure.

(4) For the purposes of this section—

(A) The term "nonprofit" as applied to any private agency, institution, or organization means one which is a corporation or association, or is owned and operated by one or more corporations or associations, no part of the net earnings of which inures, or may lawfully inure, to the benefit of any private shareholder or individual; and

(B) The term "State" includes the Commonwealth of Puerto Rico, the Northern Mariana Islands, Guam, American Samoa, the Trust Territory of the Pacific Islands, the Virgin Islands, and the District of Columbia and the term "United States" means the fifty States and the District of Columbia.

SEC. 315. [Repealed.]

SEC. 316. [Repealed.]

[[1] TITLE IX—EDUCATION, RESEARCH, TRAINING, AND DEMONSTRATIONS IN THE FIELDS OF HEART DISEASE, CANCER, STROKE, KIDNEY DISEASE, AND OTHER RELATED DISEASES

[PURPOSES

[SEC. 900. The purposes of this title are—

[(a) through grants and contracts, to encourage and assist in the establishment of regional cooperative arrangements among medical schools, research institutions, and hospitals for research and training (including continuing education), for medical data exchange, and for demonstrations of patient care in the fields of heart disease, cancer, stroke, and kidney disease, and other related diseases;

[(b) to afford to the medical profession and the medical institutions of the Nation, through such cooperative arrangements, the opportunity of making available to their patients the latest advances in the prevention, diagnosis, and treatment and rehabilitation of persons suffering from these diseases;

[(c) to promote and foster regional linkages among health care institutions and providers so as to strengthen and improve primary care and the relationship between specialized and primary care; and

[(d) by these means to improve generally the quality and enhance the capacity of the health manpower and facilities available to the Nation and to improve health services for persons residing in areas with limited health services, and to accomplish these ends without interfering with the patterns, or the methods of financing, of patient care or professional practice, or with the

[1 This title has been superseded by title XV. For transitional provision, see section 5(a)(2) of Public Law 93-641. Appendix, Vol. 1.]

administration of hospitals, and in cooperation with practicing physicians, medical center officials, hospital administrators, and representatives from appropriate voluntary health agencies.

[AUTHORIZATIONS OF APPROPRIATIONS

[SEC. 901. (a) There are authorized to be appropriated $50,000,000 for the fiscal year ending June 30, 1966, $90,000,00 for the fiscal year ending June 30, 1967, $200,000,000 for the fiscal year ending June 30, 1968, $65,000,000 for the fiscal year ending June 30, 1969, $120,000,000 for the next fiscal year, $125,000,000 for the fiscal year ending June 30, 1971, $150,000,000 for the fiscal year ending June 30, 1972, $250,000,000 for the fiscal year ending June 30, 1978, and $159,000,000 for the fiscal year ending June 30, 1974, for grants to assist public or nonprofit private universities, medical schools, research institutions, and other public or nonprofit private institutions and agencies in planning, in conducting feasibility studies, and in operating pilot projects for the establshment, of regional medical programs of research, training, and demonstration activities for carrying out the purposes of this title and for contracts to carry out the purposes of this title. Of the sums appropriated under this section for the fiscal year ending June 30, 1971, not more than $15,000,000 shall be available for activities in the field of kidney disease. Of the sums appropriated under this section for any fiscal year ending after June 30, 1970, not more than $5,000,000 may be made available in any such fiscal year for grants for new construction.

[(b) A grant under this title shall be for part or all of the cost of the planning or other activities with respect to which the application is made, except that any such grant with respect to construction of, or provision of built-in (as determined in accordance with regulations) equipment for, any facility may not exceed 90 per centum of the cost of such construction or equipment.

[(c) Funds appropriated pursuant to this title shall not be available to pay the cost of hospital, medical, or other care of patient except to the extent it is, as determined in accordance with regulations, incident to those research, training, or demonstration activities which are encompassed by the purposes of this title. No patient shall be furnished hospital, medical, or other care at any facility incident to research training, or demonstration activities carried out with funds appropriated pursuant to this title, unless he has been referred to such facility by a practicing physician or, where appropriate, a practicing dentist.

[(d) Grants under this title to any agency or institution, or combination thereof, for a regional medical program may be used by it to assist in meeting the cost of participation in such program by any Federal hospital.

[(e) At the request of any recipient of a grant under this title, the payments to such recipient may be reduced by the fair market value of any equipment, supplies, or services furnished by the Secretary to such recipient and by the amount of the pay, allowance, traveling expenses, and any other costs in connection with the detail of an officer or employee of the Government to the recipient when such furnishing

or such detail, as the case may be, is for the convenience of and at the request of such recipient and for the purpose of carrying out the regional medical program to which the grant under this title is made.

[DEFINITIONS

[SEC. 902. For the purpose of this title—

[(a) the term "regional medical program" means a cooperative arrangement among a group of public or nonprofit private institutions or agencies engaged in research, training, prevention, diagnosis, treatment, and rehabilitation relating to heart disease, cancer, stroke, or kidney disease and, at the option of the applicant, other related diseases but only if such group—

[(1) is situated within a geographic area, composed of any part or parts of any one or more States (which for purposes of this title includes the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Trust Territory of the Pacific Islands), which the Secretary determines, in accordance with regulations, to be appropriate for carrying out the purposes of this title;

[(2) consists of one or more medical centers, one or more clinical research centers, and one or more hospitals; and

[(3) has in effect cooperative arrangements among its component units which the Secretary finds will be adequate for effectively carrying out the purposes of this title.

[(b) the term "medical center" means a medical school or other medical institution involved in postgraduate medical training and one or more hospitals affiliated therewith for teaching, research, and demonstration purposes.

[(c) the term "clinical research center" means an institution (or part of an institution) the primary function of which is research, training of specialists, and demonstrations and which, in connection therewith, provides specialized, high-quality diagnostic and treatment services for inpatients and outpatients.

[(d) the term "hospital" means a hospital as defined in section 645(c) or other health facility in which local capability for diagnosis and treatment is supported and augmented by the program established under this title.

[(e) the term "nonprofit" as applied to any institution or agency means an institution or agency which is owned and operated by one or more nonprofit corporations or associations no part of the net earnings of which inures, or may lawfully inure, to the benefit of any private shareholder or individual.

[(f) the term "construction" means new construction of facilities for demonstrations, research, and training when necessary to carry out regional medical programs, alterations, major repair (to the extent permitted by regulations), remodeling and renovation of existing buildings (including initial equipment thereof), and replacement of obsolete, built-in (as determined in accordance with regulations) equipment of existing buildings.

[GRANTS FOR PLANNING

[SEC. 903 (a) The Secretary, upon the recommendation of the National Advisory Council on Regional Medical Programs established

by section 905 (hereafter in this title referred to as the "Council"), is authorized to make grants to public or nonprofit private universities, medical schools, research institutions, and other public or nonprofit private agencies and institutions, and combinations thereof, to assist them in planning the development of regional medical programs.

[(b) Grants under this section may be made only upon application therefor approved by the Secretary. Any such application may be approved only if it contains or is supported by—

[(1) reasonable assurances that Federal funds paid pursuant to any such grant will be used only for the purposes for which paid and in accordance with the applicable provisions of this title and the regulations thereunder;

[(2) reasonable assurances that the applicant will provide for such fiscal control and fund accounting procedures as are required by the Secretary to assure proper disbursement of and accounting for such Federal funds;

[(3) reasonable assurances that the applicant will make such reports, in such form and containing such information as the Secretary may from time to time reasonably require, and will keep such records and afford such access thereto as the Secretary may find necessary to assure the correctness and verification of such reports; and

[(4) a satisfactory showing that the applicant has designated an advisory group, to advise the applicant (and the institutions and agencies participating in the resulting regional medical program) in formulating and carrying out the plan for the establishment and operation of such regional medical program, which advisory group includes practicing physicians, medical center officials, hospital administrators, representatives from appropriate medical societies, voluntary or official health agencies, health planning agencies, and representatives of other organizations, institutions, and agencies concerned with activities of the kind to be carried on under the program (including as an ex officio member, if there is located in such region one or more hospitals or other health facilities of the Veterans' Administration, the individual whom the Administrator of Veterans' Affairs shall have designated to serve on such advisory group as the representative of the hospitals or other health care facilities of such Administration which are located in such region) and members of the public familiar with the need for and financing of the services provided under the program, and which advisory group shall be sufficient in number to insure adequate community orientation (as determined by the Secretary).

[GRANTS FOR ESTABLISHMENT AND OPERATION OF REGIONAL MEDICAL PROGRAMS

[SEC. 904. (a) The Secretary, upon the recommedation of the Council, is authorized to make grants to public or nonprofit private universities, medical schools, research institutions, and other public or nonprofit private agencies and institutions, and combinations thereof, to assist in establishment and operation of regional medical programs, including construction and equipment of facilities in connection therewith.

[(b) Grants under this section may be made only upon application therefor approved by the Secretary. Any such application may be approved only if it is recommended by the advisory group described in section 903(b)(4), if opportunity has been provided, prior to such recommendation, for consideration of the application by each public or nonprofit private agency or organization which has developed a comprehensive regional, metropolitan area, or other local area plan referred to in section 314(b)[1] covering any area in which the regional medical program for which the application is made will be located, and if the application contains or is supported by reasonable assurances that—

[(1) Federal funds paid pursuant to any such grant (A) will be used only for the purposes for which paid and in accordance with the applicable provisions of this title and the regulations thereunder, and (B) will not supplant funds that are otherwise available for establishment or operation of the regional "medical" program with respect to which the grant is made;

[(2) the applicant will provide for such fiscal control and fund accounting procedures as are required by the Secretary to assure proper disbursement of and accounting for such Federal funds;

[(3) the applicant will make such reports, in such form and containing such information as the Secretary may from time to time reasonably require, and will keep such records and afford such access thereto as the Secretary may find necessary to assure the correctness and verification of such reports; and

[(4) any laborer or mechanic employed by any contractor or subcontractor in the performance of work on any construction aided by payments pursuant to any grant under this section will be paid wages at rates not less than those prevailing on similar construction in the locality as determined by the Secretary of Labor in accordance with the Davis-Bacon Act, as amended (40 U.S.C. 276a—276a–5); and the Secretary of Labor shall have, with respect to the labor standards specified in this paragraph. the authority and functions set forth in Reorganization Plan Numbered 14 of 1950 (15 F.R. 3176; 5 U.S.C. 133z–15) and section 2 of the Act of June 13, 1934, as amended (40 U.S.C. 276c).

[NATIONAL ADVISORY COUNCIL ON REGIONAL MEDICAL PROGRAMS

[SEC. 905. (a)[2] The Secretary may appoint, without regard to the civil service laws, a National Advisory Council on Regional Medical

---

[1] See footnote No. 1 on page 55.

[2] Sec. 107 of P.L. 91–515, which expanded the Council provided the following:

[(b) Of the persons first appointed under section 905(a) of the Public Health Service Act to serve as the four additional members of the National Advisory Council on Regional Medical Programs authorized by the amendment made by subsection (a) of this section—

[(1) one shall serve for a term of one year,

[(2) one shall serve for a term of two years,

[(3) one shall serve for a term of three years, and

[(4) one shall serve for a term of four years,

as designated by the Secretary of Health, Education, and Welfare at the time of appointment.

[(c) Members of the National Advisory Council on Regional Medical Programs (other than the Surgeon General) in office on the date of enactment of this Act shall continue in office in accordance with the term of office for which they were last appointed to the Council.

Programs. The Council shall consist of the Assistant Secretary of Health, Education, and Welfare for Health and Scientific Affairs, who shall be the Chairman, the Chief Medical Director of the Veterans' Administration who shall be an ex officio member, and twenty members, not otherwise in the regular full-time employ of the United States, who are leaders in the fields of the fundamental sciences, the medical sciences, health care administration, or public affairs. At least two of the appointed members shall be practicing physicians, one shall be outstanding in the study or health care of persons suffering from heart disease, one shall be outstanding in the study or health care of persons suffering from cancer, one shall be outstanding in the study or health care of persons suffering from stroke, one shall be outstanding in the study or health care of persons suffering from kidney disease, two shall be outstanding in the field of prevention of heart disease, cancer, stroke, or kidney disease, and four shall be members of the public.

[(b) Each appointed member of the Council shall hold office for a term of four years, except that any member appointed to fill a vacancy prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term, and except that the terms of office of the members first taking office shall expire, as designated by the Secretary at the time of appointment, four at the end of the first year, four at the end of the second year, four at the end of the third year, and four at end of the fourth year after the date of appointment. An appointed member shall not be eligible to serve continuously for more than two terms.

[(c) The Council shall advise and assist the Secretary in the preperation of regulations for, and as to policy matters, arising with respect to, the administration of this title. The Council shall consider all applications for grants under this title and shall make recommendations to the Secretary with respect to approval of applications for and the amounts of grants under this title.

[REGULATIONS

[SEC. 906. The Secretary, after consultation with the Council shall prescribe general regulations covering the terms and conditions for approving applications for grants under this title and the coordination of programs assisted under this title with programs for training, research, and demonstrations relating to the same diseases assisted or authorized under titles of this Act or other Acts of Congress.

[INFORMATION ON SPECIAL TREATMENT AND TRAINING CENTERS

[SEC. 907. The Secretary shall establish, and maintain on a current basis, a list or lists of facilities in the United States equipped and staffed to provide the most advanced methods and techniques in the diagnosis and treatment of heart disease, cancer, stroke, or kidney disease, together with such related information, including the availability of advanced specialty training in such facilities, as he deems useful, and shall make such list or lists and related information readily available to licensed practitioners and other persons requiring such information. To the end of making such list or lists and other infor-

mation most useful, the Secretary shall from time to time consult with interested national professional organizations.

[REPORT

[SEC. 908. On or before June 30, 1967, the Surgeon General, after consultation with the Council, shall submit to the Secretary for transmission to the President and then to the Congress, a report of the activities under this title together with (1) a statement of the relationship between Federal financing and financing from other sources of the activities undertaken pursuant to this title, (2) an appraisal of the activities assisted under this title in the light of their effectiveness in carrying out the purposes of this title, and (3) recommendations with respect to extension or modification of this title in the light thereof.

[RECORDS AND AUDIT

[SEC. 909. (a) Each recipient of a grant or contract under this title shall keep such records as the Secretary may prescribe, including records which fully disclose the amount and disposition by such recipient of the proceeds of such grant or contract, the total cost of the project or undertaking in connection with which such grant or contract is made or used, and the amount of that portion of the cost of the project or undertaking supplied by other sources, and such records as will facilitate an effective audit.

[(b) The Secretary of Health, Education, and Welfare and the Comptroller General of the United States, or any of their duly authorized representatives, shall have access for the purpose of audit and examination to any books, documents, papers, and records of the recipient of any grant under this title which are pertinent to any such grant.

[MULTIPROGRAM SERVICES

[SEC. 910. (a) To facilitate interregional cooperation and develop improved national capability for delivery of health services, the Secretary is authorized to utilize funds appropriated under this title to make grants to public or nonprofit private agencies and institutions or combinations thereof and to contract for—

[(1) programs, services, and activities of substantial use to two or more regional medical programs;

[(2) development, trial, or demonstration of methods for control of heart disease, cancer, stroke, kidney disease, or other related diseases;

[(3) the collection and study of epidemiologic data related to any of the diseases referred to in paragraph (2);

[(4) development of training specifically related to the prevention, diagnosis, or treatment of any of the diseases referred to in paragraph (2), or to the rehabilitation of persons suffering from any of such diseases; and for continuing programs of such training where shortage of trained personnel would otherwise limit application of knowledge and skills important to the control of any of such diseases; and

[(5) the conduct of cooperative clinical field trials.

[(b) The Secretary is authorized to assist in meeting the costs of special projects for improving or developing new means for the delivery of health services concerned with the diseases with which this title is concerned.

[(c) The Secretary is authorized to support research, studies, investigations, training, and demonstrations designed to maximize the utilization of manpower in the delivery of health services.]

XII. ADDITIONAL VIEWS OF MR. HATCH AND MR. HAYAKAWA ON S. 2410

While we support the general thrust of this bill in furthering national health planning and health resources, physicians of our States have expressed their grave concern over the nation set out in Sec. 141 to mandatorily extend certificate of need requirements for major medical equipment into their private offices. They point out that although every State has had the existing discretion to do that very thing since P.L. 93–641 was enacted three and one-half years ago, only seven—Colorado, Hawaii, Iowa, Minnesota, Rhode Island, Virginia, and Wisconsin—have found it desirable to do so in any form. Moreover, almost three times that number of states (20) have done just the opposite—considered such an idea and expressly rejected it.

For the information of our colleagues these states are:

Alabama	New Mexico
Alaska	New York
Arizona	Ohio
Arkansas	Oregon
California	South Carolina
Florida	South Dakota
Illinois	Tennessee
Kentucky	Texas
Maine	West Virginia
New Jersey	Wyoming

What we would be doing, then, by leaving this types of mandate in S. 2410, is telling those 20 States and the 23 others which have not moved to enact such a provision—a total of 43—that even though we promised them in the original law that this would be something they should decide for themselves, our superior federal judgment is now going to displace that state prerogative. In our view, this is violating the whole spirit of the pledge Congress made back in 1974 to leave these types of essential policy matters to state and local determination—once the basic certificate of need concept called for in the law were implemented.

The States have previously been given notice that they have until 1980 to design the type of certificate of need program they think will work best in their respective jurisdiction. As of now, 38 States have adopted statutes of widely varying degrees while 12 have yet to express themselves on the issue.

The State of Utah is one of those which currently has no CON law. Senator Hatch pointed out to Senator Eagleton, Senator Schweiker and Senator Stafford at the Committee mark-up that their States likewise have not acted—and hoped that they might have joined in preserving Missouri's Pennsylvania's and Vermont's option to proceed as they

see fit in the controversial area of invoking controls beyond the traditional institutional setting. We hope now that our other Senate colleagues will agree that this is the right approach.

We further appeal to our forty Senate colleagues to consider whether they are prepared to preempt their State legislatures—all of which have specifically exempted physicians' offices from certificate of need—by approving Sec. 141 of S. 2410 without further alteration. In addition, we think it is important to recognize that other States, like New Jersey and Michigan, are currently debating this issue and have not yet chosen to apply CON to other than inpatient health care facilities or ambulatory surgical and kidney dialysis units.

As for our friends from States which have enacted law in this area, we would just say that the language Senator Hatch unsuccessfully proposed in Committee to delete the CON requirement to physicians' offices would not affect their States' CON laws in the least—which is precisely the point: whatever CON law works for any State should be protected and we of the Senate Human Resources Committee should not be in the business of trying to supercede or place additional conditions upon it. In short, the Hatch amendment which may be resubmitted on the Senate floor would have offered a way States, which want to take that historic first regulatory step into private offices, would be free to so experiment, but those which are reluctant to breach that barrier would be equally free to so refrain.

We think it would be well for each of us to reflect for just a moment on what S. 2410 would have us do in terms of the State experience relative to certificate of need outside the institutional setting—(i.e., HMO's and physicians' offices). Since 24 States have so far said "yes" to HMO inclusion while 20 have said "no" to physicians' office coverage, one would think the logical direction for us to be proceeding in—if we are going to impose any additional requirements at all—would be along those lines. The anomaly of the current bill, however, is that it seeks to do just the opposite.

We are at a loss to understand the rationale for trying to discourage certificate of need requirements for HMO's while encouraging coverage of other far less institutionalized ambulatory facilities. Apparently the Committee believes it necessary in order for them to survive. We do not argue the point. We personally believe the States should retain the power to decide for themselves on any expansion of certificate of need outside the hospital setting—but for us to start dictating the terms and singling out some ambulatory facilities for mandatory inclusion and others for mandatory exclusion is in our view very arbitrary and totally inappropriate.

We would be well-advised to follow the lead of our House counterparts in this area. Paul Rogers' Health Subcommittee recognized the injudiciousness of the approach now in S. 2410 and essentially deleted the provision applying certificate of need to physicians' office when it marked up its companion bill H.R. 11488, on March 8. The full committee then affirmed that action when it ordered the bill reported on April 11.

This is a classic case of state preemption. This entire area—outside the institutional setting (i.e., hospital construction)—should be handled on a state-by-state basis dictated by local needs and preferences. While opponents of the Hatch amendment argued that Sec. 141 extends only to expensive new equipment such as CT scanners (which by the way he was willing to exempt from the coverage of his amendment) and it is necessary in order to keep physicians groups from circumventing the law by buying the equipment for a hospital unable to do so, and perhaps locating it across the street from that institution—there has been no reported evidence confirming any systematic pattern of such abuses to justify an across-the-board legislative response.

In fact, since the mark-up was concluded, we have acquired a recent National Electrical Manufacturers Association survey which shows that of the over 900 CT scanners in the United States, only 4.5 percent are in the offices of private physicians. We believe that the results of this study should allay the fears of those who foresee proliferation of CT scanners in doctors' offices across the street from hospitals that do not have innovative diagnostic equipment.

In summary, we are not suggesting that we mandatorily exclude any non-hospital entities from certificate of need, but neither should we, as a matter of health public policy, mandatorily include them.

Orrin G. Hatch.
S. I. Hayakawa.

○